

Michigan Department of Community Health
Task Force on Nursing Practice

Final Report and Recommendations

April 2012

This page intentionally left blank.

MDCH - Task Force on Nursing Practice - List of Members – December 2010 to April 2012***Voting Members***

James Fischer, MS, MBA, RN, NEA-BC [TFNP Co-Chair]

Christine Pacini, PhD, RN [TFNP Co-Chair]

Shari Carson, RN, BSN, NHA, CRRN, CDON

Katie Childs,² RN, BSN,

Regina Crooks, BSN, RN

Elizabeth Henry, RN, MN

Mary Korsgren,³ LPN

Mary Kravutske, PhD, RN

Nancy Martin, MSN, RN

Charlotte Mather,⁴ MSN, RN,

Patricia McCain, ADN, RN, BS, PSN

Patrick Miller, RN, MBA, MHSA, FACHE

Patricia Natale, RN, MSN, NEA-BC

MaryLee Pakieser,⁵ RN, MSN, FNP-BC

Linda Pekar, RN, BA, CLNC, CHPN

Amy Perry,⁶ MSN, RN

Joanne Pohl, PhD, ANP-BC, FAAN, FAANP

Erin Savelle,⁷ RN, ADN, BALaura Schmidt,⁸ MSN, FNP-BCKerri Schuiling,⁹ PhD, CNM, NP-BC, FACNM, FAAN

Linda Scott, PhD, RN, NEA-BC, FAAN

Carole Stacy, MSN, RN

Linda Taft,¹⁰ RN

Henry Talley V, PhD, CRNA, MSN, MS, BA

Nancy Vecchioni, RN, MSN, CPHQ

Kathleen Vollman,¹¹ MSN, RN, CCNS, FCCM, FAAN

Teresa Wehrwein, PhD, RN, NEA-BC

Ex-Officio Members

Melanie Brim, MHA

Jeanette Klemczak,¹² MSN, RN, FAAN***Titles & Organizations¹***Vice President, Patient Care Services/Chief Nursing Officer
Munson Medical CenterDean and Professor, College of Health Professions and
McAuley School of Nursing, Univ. of Detroit Mercy

Director of Clinical Services, NexCare Health Systems

1st Vice President, Michigan Nursing Students Assoc.

Personal Health Manager

Calhoun County Public Health Department

Senior Vice President and Chief Nursing Officer

Sparrow Hospital and Health System

Michigan Licensed Practical Nurses Association Board

Nursing Development and Research Administrator

Henry Ford Hospital

President/Chief Executive Officer, VitalCare

Chief Nursing Officer, Genesys Regional Medical Center

School Nurse Consultant

Saginaw Township Community Schools

VP & Chief Operating Officer, Hospice of Michigan

Senior Vice President and Chief Nursing Officer (Retired)

Detroit Medical Center

President, Michigan Council of Nurse Practitioners

Vice President, Clinical Operations

Visiting Nurse Association of Southeast Michigan

Member, Michigan Board of Nursing

Professor Emerita

The University of Michigan School of Nursing

President, Michigan Nursing Students Association

Michigan Council of Nursing Education Administrators

Northwestern Michigan College

Dean, Oakland University School of Nursing

Professor and Associate Dean, Grand Valley State Univ.

Kirkhof College of Nursing

Director, Michigan Center for Nursing

Chair, Coalition of Michigan Organizations of Nursing

Director, Nurse Anesthesia Program & Assoc. Professor

Michigan State University College of Nursing

Vice President of Medicare Operations, MPRO

President, Michigan Clinical Nurse Specialists Assoc.

Assoc. Dean, Academic & Clinical Affairs, Assoc. Prof.

Michigan State University College of Nursing

Deputy Director, Policy and Planning

Michigan Department of Community Health

Chief Nurse Executive

Michigan Department of Community Health

TFNP Workgroup Experts – January 2011 – April 2012***Workgroup Experts***

Cynthia Archer-Gift PhD, MSN, BSN

Andrea Bostrom, PhD, PMHCNS-BC

Dianne Conrad, DNP, RN, FNP-BC

Craig Huard,¹³ MSN, CRNA, MBAKatie Lavery,¹⁴ MS, BSN, CNM, RN

Debra Leblanc, BSN, MM, NEA-BC

Marie Patrick, RN, NHA

Titles & Organizations

Associate Professor, Wayne State University

College of Nursing

Professor, Grand Valley State University

Kirkhof College of Nursing

Nurse Practitioner, Cadillac Family Physicians

President, Michigan Association of Nurse Anesthetists

Chair, Michigan Board of Nursing

Vice President, Patient Care Services

Detroit Receiving Hospital

Nursing Home Administrator

Holt Senior Care & Rehabilitation Center

TFNP Design Group – October and November 2010***Design Group Members***

Elizabeth Henry, RN, MN

Christine Pacini, PhD, RN

Dennis Paradis, MPH

Joanne Pohl, PhD, ANP-BC, FAAN, FAANP

Mary-Anne D. Ponti, RN, MS, MBA, CNAA-BC

Marilyn Rotherth, PhD, RN

Carole Stacy, MSN, RN

Melanie B. Brim, MHA

Titles & Organizations

Senior Vice President and Chief Nursing Officer

Sparrow Hospital and Health System

Dean and Professor, College of Health Professions and

McAuley School of Nursing, Univ. of Detroit Mercy

Institute for Health Care Studies, Michigan State University

College of Human Medicine

Professor, The University of Michigan School of Nursing;

Principal Investigator, Institute for Nursing Centers

Chief Operating Officer and Chief Nurse Executive

Northern Michigan Regional Hospital

Dean Emerita, College of Nursing

Michigan State University

Director, Michigan Center for Nursing

Director, Bureau of Health Professions

Michigan Department of Community Health

End Notes¹ Listed as per December 2010² Orthopedic Staff Nurse, Spectrum Health Blodgett Hospital.³ Staff LPN, St. Joseph Health System – Home Care and Hospice.⁴ TFNP Member through December 2011. Currently, Chief Nursing Officer, Sheridan Hospital, Sheridan, Wyoming.⁵ Nurse Practitioner, Veterans Affairs Clinic – Traverse City, Michigan.⁶ Clinical Operations Specialist, Blue Cottage Consulting; formerly, Director of Quality Improvement, The University of Michigan Health System.⁷ Clinical Decision Unit Staff Nurse, St. John Macomb.⁸ Director, Nursing and Allied Health, Northwestern Michigan College⁹ Formally, Dean, Northern Michigan University College of Nursing¹⁰ Registered Nurse, Macomb Township Surgery Center, St. John Providence Health System¹¹ Critical Care Clinical Nurse Specialist, Educator, & Consultant; ADVANCING NURSING LLC.¹² Currently, Director, Healthcare Market Talent, Michigan Workforce Development Agency.¹³ Certified Registered Nurse Anesthetist, Port Huron Hospital; Clinical and Didactic Instructor.¹⁴ Certified Registered Nurse Midwife, Bronson Women's Services and Henry Ford West Bloomfield Hospital.

Foreword

Nursing Practice and the Health and Safety of Michigan's People

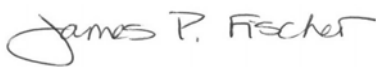
Nurses are the largest licensed health professional group in the state - Michigan has nearly 170,000 licensed nurses. Nurses provide the majority of healthcare services to the people of Michigan and the nation. Nursing practice - the professional healthcare services of nurses - is the foundation upon which quality healthcare and patient safety are built.

This document, the Final Report of the Michigan Department of Community Health -- Task Force on Nursing Practice (TFNP), considers current and future nursing practice in the context of a rapidly changing healthcare environment, including the ways in which: a) nursing practice is critical in maintaining and improving the health and safety of the people of Michigan; b) healthcare institutions and healthcare regulators incorporate nursing practice into healthcare; and c) Michigan's population and healthcare stakeholders, technologies, and regulators impact the practice of nursing. The vision of the TFNP is that: *Michigan's nurses provide the public with safe high-quality health care by practicing to the full extent of their education and competencies.* Realization of this vision will require changes in Michigan regulations, nursing education and practice, and healthcare systems.

Nurses practice their profession in a healthcare environment that was transformed between 1950 and 2000 by healthcare research, technological advances, and a Michigan population in which over 90% had public or private health insurance to pay for care. Nursing practice today requires greatly increased scientific knowledge, clinical decision-making competencies, and patient care approaches that demand continuous learning of new technologies and supervision of assistive personnel, as well as the caring principles that ground the nursing profession.

The post-2000 healthcare environment is in the early stages of yet another transformation, one based on growing need as Michigan's population ages, rising healthcare costs, a declining portion of residents with adequate health insurance, and fewer healthcare professionals (per capita) to provide care. The TFNP recommendations are made within the 2011/12 context of rising demand and diminishing supply. The demographics of our nation and state are inescapable, requiring difficult decisions and changes if care is to be available to all.

This report from the MDCH-TFNP includes recommendations to the Director of MDCH and others for improvement of nursing practice through modernization of nursing regulations and policies and therefore improvement of healthcare access, safety, and quality. The people of Michigan will benefit from implementation of these recommendations.



James P. Fischer, MS, MBA, RN, NEA-BC
TFNP Co-Chair
Vice President, Patient Care Services
Chief Nursing Officer
Munson Medical Center



Christine M. Pacini, PhD, RN
TFNP Co-Chair
Dean of the College of Health Professions and the
McAuley School of Nursing
University of Detroit Mercy

Michigan Department of Community Health Task Force on Nursing Practice (TFNP) – Final Report and Recommendations

Table of Contents

Purpose and Charge	1
Background: Licensure and Education of Nurses in Michigan	2
History and Process	3
Recommendation Abstracts	5
Nursing Practice Recommendations and Position Papers	
1. Improve Practice for Advanced Practice Registered Nurses	7
2. Modernize Registered Nurses’ Scope and Standards of Practice	17
3. Clarify Delegation of Nursing Functions	27
4. Delineate the Practice and Role of Licensed Practical Nurses	35
5. Update Regulation of Nursing Assistive Personnel	41
6. Mitigate Human Factors in Patient Care Quality and Safety	53
7. Increase Practice Efficiencies in Nursing & Healthcare	65
8. Advance Technology in Nursing Practice and Healthcare	75
9. Enable Competition and Entrepreneurship in Healthcare Markets.....	93
10. Establish the Michigan Nursing Practice Council	101
Appendices	103
Appendix A: TFNP History	105
TFNP Design Group	105
TFNP Interaction and Approval Rules.....	107
TFNP Implemented Organizational Structure Chart.....	109
TFNP Appointment Letter	110
TFNP Member and Expert Biosketches.....	111
Appendix B: Additional TFNP Products	117
Organizational Framework for TFNP Issues	117
Crosswalk: Comparing National Standards with the Michigan Public Health Code.....	127
TFNP Information Gathered: Nursing Practice Issue Statements and Five Regional Forums	167
Appendix C: Definitions, Acronyms & Useful Websites	173
Acknowledgements	179

Michigan Department of Community Health Task Force on Nursing Practice

Purpose and Charge

Rationale

The health and safety of Michigan residents require that nursing standards, nursing education, and appropriate nursing practice be modernized to meet current needs. *The Nursing Agenda for Michigan* includes action steps to address the nursing shortage and strengthen the nursing profession through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. Michigan must maintain high quality health care and increase respect for professional nurses while increasing the nursing workforce. Considering healthcare system changes, the modernization of nursing practice is both timely and essential to assure that nurses may address the healthcare needs of Michigan's people. [See: *The Nursing Agenda for Michigan*, 2006; *Final Report of the MDCH Task Force on Nursing Regulation*, 2007; and *Final Report of the MDCH Task Force on Nursing Education*, 2009.]

Task Force on Nursing Practice

- **Establish** a Task Force on Nursing Practice (TFNP) composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders.
 - **Charge** the TFNP to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to modernize the practice of nursing and the practice environment for nurses in Michigan, thereby protecting the health and safety of Michigan residents.
 - **Activities:** TFNP shall: engage in appropriate information gathering; inform decision-making through consultation with national experts and organizations; refer to national standards and acknowledged best practices for nursing practice and the practice environment for nurses; conduct deliberations; and promulgate recommendations to address the issues.
1. Review and recommend improvements to nursing practice and practice environments, with emphasis on high-quality patient-centered care, evidence-based care, inter-professional teams, preventive care, healthcare system changes, and relevant national reports and models; include issues referred to the TFNP by the 2007 Michigan Task Force on Nursing Regulation and the 2008/9 Michigan Task Force on Nursing Education, identify additional nursing practice issues as appropriate; and recommend related changes in uniform nursing credentials and conditions of practice.
 2. Identify changes needed in the Public Health Code and related rules and regulations, plus nursing standards, nursing education, and nursing credentials, to implement the recommendations made. Recommend these changes to the Director of the Michigan Department of Community Health; and support the realization and implementation of the recommended changes.
 3. Recommend and support education of employers, nurses, other health professionals, student nurses, faculty, and the public on regulatory changes in nursing practice, credentials, and standards.

Background: Licensure and Education of Nurses in Michigan

Licensure: To protect the health and safety of the people of Michigan, licensure of physicians, nurses, and 21 other health professions is required by the Public Health Code, Public Act 368 of 1978 as amended. Licensure of health professions is performed by the Michigan Department of Licensing and Regulatory Affairs (MDLARA), Bureau of Health Professions (BHP) upon the recommendation of the board of a specific health profession. Michigan nurses have been licensed since 1909 (Public Act 319 of 1909). The Michigan Board of Nursing (MBON), consistent with other health professions boards, is composed of volunteers appointed by the Governor and operates in accordance with the Public Health Code and MBON Administrative Rules.

In this report, the word “nurse” when used without modification or amplification means a person licensed by the State of Michigan as a Registered Nurse (RN) or Advanced Practice Registered Nurse (APRN). APRNs hold RN licensure plus specialty certification based on 1) advanced education (a nursing master’s degree or nursing doctoral degree) and 2) meeting the standards of national advanced practice nursing organizations through examination and continuing education.

Education: Registered Nurses (RNs) are educated in either an Associate Degree in Nursing (ADN) program or a Bachelor of Science Degree in Nursing (BSN) program. For example:

- An approved ADN program includes basic science, mathematics, and writing prerequisites, plus social sciences and communications courses, physical science courses including chemistry, biology, anatomy, physiology, microbiology, pharmacology, psychology, mental health, pediatrics, and nursing courses such as fundamentals in nursing care I & II, maternity nursing care, chronic and acute nursing care, healthy lifestyles, human growth and development, and clinical experience.
- An accredited BSN program includes higher-level pre-nursing courses in algebra, statistics, chemistry, biology, science-writing, anatomy, physiology, nutrition, pathophysiology, microbiology, psychology, ecology, and social sciences. The nursing curriculum includes: pharmacology; health assessment and therapeutics; scholarly nursing practice; acute nursing care of adults; mental health/psychiatric nursing; care of the childbearing family; nursing care of children, adolescents, and families; community health and population nursing; nursing leadership; and clinical experience.

Following licensure, all RNs and APRNs must engage in lifelong nursing education for re-licensure and recertification; continuing education hours are required for each re-licensure and recertification.

Advanced Practice Registered Nurses (APRNs) generally have a BSN degree, significant nursing experience, and a master’s degree or doctoral degree in a specific area of nursing practice. These degrees require intensive graduate coursework, including sciences, statistics, healthcare policy and research, advanced pharmacology, advanced pathophysiology, and rigorous nursing specialty courses. Nurse Anesthetists, for example, complete 8 anesthesia courses and 5 clinical anesthesia practicums. Clinical Nurse Specialists complete courses in advanced physical assessment and clinical decision-making, plus four semesters of clinical internship. After receiving their master’s or doctoral degree, APRNs must meet the standards of national advanced practice nursing organizations through examination and continuing education.

Competencies are based on a nurse’s education, continuing education, certifications, and clinical experience. Competencies must be both demonstrated and documented.

The *Nursing Agenda for Michigan*, a strategic plan for the future of nursing in Michigan, is available at: www.michigan.gov/mdch/ocne, www.micnwp.org, and www.micomon.org.

TFNP History and Process

TFNP History

Michigan's strategic plan for addressing nursing practice, education, and workforce issues, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents.

The TFNP is composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, clinics, community-based care, and home-based care), nursing education programs, nurse-employers, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met for the first time in December 2010 and continued through April 2012 to identify key issues in Michigan and the nation affecting nursing practice and patient care. The Task Force gathered information, consulted with state and national experts in nursing practice and policy, and considered issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The MDCH Task Force on Nursing Practice Final Report will be disseminated through meetings, websites, nursing education classes, and conferences.

A TFNP Design Group met in the fall of 2010 to plan the task force and its work. The full TFNP met monthly from December 2010 through April 2012, with additional Workgroup meetings. The TFNP gathered information through five statewide forums with over 600 participants, 70 nursing practice issue forms submitted by the public and the nursing community, consultation with state and national experts in nursing practice, law, and policy, a two-day retreat with state and national speakers, and special work sessions with content experts (see Appendix B). The Task Force considered issues identified in the *Nursing Agenda for Michigan* and by the nursing community, stakeholders, the 2008 MDCH Task Force on Nursing Regulation, and the 2009 Task Force on Nursing Education. To guide deliberations, the TFNP developed a vision statement: *Michigan's nurses provide the public with safe, high-quality health care by practicing to the full extent of their education and competency.*

The TFNP viewed its work in the context of national and state demographics, the current economic environment, and healthcare system changes at the national and state levels. Issues were considered in terms of three priorities: ensuring high-quality patient care, maintaining safe patient care, and improving the productive capacity of nurses in Michigan. Issues identified as high priority were developed into ten Nursing Practice Position Papers. The first five (1-5) position papers recommend transformative changes in the Michigan nursing practice and regulatory system. The next four (6-9) papers focus on healthcare systems changes and regulatory changes needed to improve the quality, safety, and efficiency of patient care; and the final position paper (10) recommends the establishment of the Michigan Nursing Practice Council. This structure is modeled after the Michigan Nursing Education Council and will function as a successor organization to the TFNP, charged to implement Task Force recommendations and advise the MDCH on matters of nursing practice.

TFNP Process and Outcomes

The TFNP held twelve five-hour meetings from December 6, 2010 through April 2, 2012. Attendance at meetings averaged over 80%. The TFNP membership: a) adopted rules for interaction and decision-making (see Appendix A); and b) committed to meeting participation in person or by teleconference. Additional document review and approval processes were conducted by website, email and fax. The members of the task force were guided by Co-Chairs James Fischer (Vice President Patient Care Services/Chief Nursing Officer at Munson Medical Center) and Dr. Christine Pacini (Dean and Professor

at the College of Health Professions and McAuley School of Nursing at the University of Detroit Mercy) in identifying and discussing issues, and making decisions. Using the 80/20 rule for adoption, the TFNP members prioritized issues, grouped them under ten major headings, and broke into Workgroups to edit multiple drafts of each nursing practice position paper. Each TFNP member voted on all ten position papers; almost all votes were unanimous for approval and all votes were well over 90% for approval; members representing government entities did not vote. The TFNP Recommendation Abstracts are presented on the next page, followed by the complete text of all approved position papers. The Appendices include TFNP History (including member bio-sketches), additional TFNP products, compiled definitions and acronyms, and websites for reference.

Michigan Department of Community Health-Task Force on Nursing Practice Recommendation Abstracts

To improve access to safe, high quality healthcare for Michigan residents and in alignment with Gov. Snyder's 2011 *Health and Wellness* message, Government and nursing regulators must change statutes and regulations, and nurses and nurse-employers must make changes to the nursing practice environment to:

- 1. Improve Practice for Advanced Practice Registered Nurses** - Remove barriers to full independent practice for Advanced Practice Registered Nurses [APRNs]. APRNs must practice in Michigan to the full extent of their required education and competencies.
- 2. Modernize Registered Nurses' Scope and Standards of Practice** - Enable all Registered Nurses (RNs) in Michigan to practice to the full extent of their required education and competencies.
- 3. Clarify Delegation of Nursing Functions** - Ensure a clear definition of nursing delegation to healthcare personnel. Remove the nursing delegation conflicts in Michigan statutes and regulations.
- 4. Delineate the Practice and Role of Licensed Practical Nurses** - Regulate all nursing titles, definitions, roles, delegation, and practice under the Nursing Section of the Michigan Public Health Code.
- 5. Update Regulation of Nursing Assistive Personnel** - Require that Nursing Assistive Personnel [NAPs] perform nursing functions under the delegation and supervision of a Registered Nurse. Regulate NAP titling, education, and roles under the Nursing Section of the Michigan Public Health Code only.
- 6. Mitigate Human Factors in Patient Care Quality and Safety** - Nurses and nurse-employers must collaborate to ensure patient care is provided in care environments that take human factors into account. Government must ensure that care environments are safe for both patients and nurses.
- 7. Increase Practice Efficiencies in Nursing & Healthcare** - Nurses must be leaders, decision makers, and active participants in planning and restructuring care processes and operational systems to ensure patient care efficiencies. Modernize Federal and State statutes and regulations to improve efficiency.
- 8. Advance Technology in Nursing Practice and Healthcare** - Ensure Healthcare Technology [HT] supports the delivery and documentation of nursing patient care by making nurses active decision makers in selection, design, development, implementation, and evaluation of HT-based systems and devices.
- 9. Enable Competition and Entrepreneurship in Healthcare Markets** - Ensure that the profession of nursing is identified in the MPHIC as a "learned profession", and therefore that professional nurses may own and operate a professional limited liability company or professional services corporation offering healthcare services, and receive direct payment or reimbursement for those services.
- 10. Establish the Michigan Nursing Practice Council** - Ensure that the Michigan Department of Community Health - Office of the Chief Nurse Executive is directed to establish and maintain the Michigan Nursing Practice Council, an overarching leadership group with staff resources to support planning, implementation, and evaluation of TFNP recommendations.

See the following pages for the full text of all TFNP Recommendations.

Michigan Department of Community Health -Task Force on Nursing Practice Recommendations

- 1. Improve Practice for Advanced Practice Registered Nurses**
- 2. Modernize Registered Nurses' Scope and Standards of Practice**
- 3. Clarify Delegation of Nursing Functions**
- 4. Delineate the Practice and Role of Licensed Practical Nurses**
- 5. Update Regulation of Nursing Assistive Personnel**
- 6. Mitigate Human Factors in Patient Care Quality and Safety**
- 7. Increase Practice Efficiencies in Nursing & Healthcare**
- 8. Advance Technology in Nursing Practice and Healthcare**
- 9. Enable Competition and Entrepreneurship**
- 10. Establish the Michigan Nursing Practice Council**

MDCH – Task Force on Nursing Practice – Position Paper 1

Improve Practice for Advanced Practice Registered Nurses (APRNs): Definitions, Titles, Licensure, and Practice

Recommendation: To improve access to health care for Michigan residents, all statutory and regulatory barriers to full independent practice for Advanced Practice Registered Nurses [APRNs] must be removed. APRNs must be able to practice in Michigan to the full extent of their required education and competencies.

Definition: Advanced Practice Registered Nurse (APRN) is a registered nurse who holds second licensure and/or certification¹ in one of the current² APRN roles [Certified Nurse Anesthetist, Certified Nurse Midwife, Certified Nurse Practitioner, and Clinical Nurse Specialist] by virtue of additional knowledge and skills gained through an advanced formal education program of nursing that has national nursing accreditation. This advanced formal education program of nursing in one of the four APRN roles shall result in a minimum of a nursing master's degree, a post-nursing-master's-degree specialty certificate, or a nursing doctorate.³ APRNs also must meet the certification requirements of appropriate national nursing certification bodies. See Appendix A to this Position Paper for recommended definitions of the four APRN roles based on the *Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education*, National Council of State Boards of Nursing; July 7, 2008.

Summary of Issue

Demand for healthcare services is increasing and will continue to rise as Michigan's percentage of residents over age 65 grows.⁴ Older people have more chronic conditions and use more health care. In addition, health insurance changes are expected to shift a minimum of 1.5 million persons from "uninsured" to "insured" in Michigan, further increasing healthcare demand. APRNs educated in Michigan often leave the state to find a more supportive practice environment.⁵ Forty-two states and the District of Columbia are rated as having better APRN practice environments than does Michigan.⁶ Sixteen states and the District of Columbia provide independent practice for APRNs.⁷ To meet demand for healthcare services, Michigan needs to attract and retain as many APRNs as possible. The competition for APRNs is one that Michigan residents cannot afford to lose.^{8 9}

Summary of Solution

To improve Michigan residents' access to the high-quality, safe, cost-effective healthcare provided by APRNs,¹⁰ the State must remove barriers to APRN practice that put Michigan at a disadvantage in attracting and keeping these healthcare professionals. State Government must change Michigan statutes and regulations to include clear APRN definitions, title protection, second licensure, and independent practice for all four roles of certified APRNs - Certified Nurse Anesthetist, Certified Nurse Midwife, Certified Nurse Practitioner, and Clinical Nurse Specialist. State Government must remove barriers so that APRNs may practice in Michigan to the full extent of their required education and competencies.

Sub-Recommendations and Reasons

Recommendation 1a - APRN Regulatory Recognition

To improve access to healthcare for Michigan residents, State Government must make changes in the Michigan Public Health Code (MPHC) and the Michigan Board of Nursing (MBON) Administrative Rules to include definitions of all 4 roles of APRNs, and provide title protection, second licensure, and independent practice for APRNs.¹¹ Individuals granted "Specialty Certification" (or any other equivalent certification) by the MBON, who met the requirements for certification at the time, and have continued to practice under that certification should be "grandfathered in" to the definitions of all four roles of

APRNs.¹² State Government¹³ should make specific provisions and procedures to “grandfather” CNSs, since their role has not previously been identified in the MPHC.¹⁴

Reasons for Recommendation 1a - Michigan will continue to have difficulty competing with other states for APRNs until Michigan has a supportive regulatory structure for APRNs. MPHC definitions, title protection, second licensure, and independent practice are needed to: a) allow APRNs to practice independently in Michigan to the full extent of their required education and competencies; b) clarify reimbursement structures; and c) provide clear information and assurance for the public through second licensure of APRNs. At present, the MPHC does not provide definitions, title protection, second licensure, or independent practice for any of the APRN roles. Section 333.17210 of the MPHC gives the Board of Nursing the ability to issue a specialty certification to registered professional nurses that have received advanced training in the APRN roles of Certified Nurse Anesthetist, Certified Nurse Midwife, and Certified Nurse Practitioner, but, in an oversight, does not identify the fourth APRN role - Clinical Nurse Specialist (CNS). Michigan currently has people called Clinical Nurse Specialists who do not have the education and credentials for this role and who do not meet national standards.¹⁵ Those CNSs who **do** have the education and credentials for their role must be grandfathered into the APRN category (see Appendix B). The currently practicing APRNs who are grandfathered into the revised statutes and regulations will continue to provide excellent care to patients in Michigan at a time when more providers are needed.¹⁶

Recommendation 1b - APRN Statutory Changes

To improve access to healthcare for Michigan residents, State Government must include Advanced Practice Registered Nurse (APRN) practice as a learned profession in the Michigan Limited Liability Company Act, Public Act 23 of 1993, and in the Michigan Professional Services Corporation Act of 1962, so that APRNs may organize professional limited liability companies or professional services corporations to provide professional services.¹⁷

Reasons for Recommendation 1b - Michigan residents cannot afford to lose the national competition for APRNs. Michigan has consistently received a grade of “F” in the rankings of states as APRN practice locations.¹⁸ Currently in Michigan, only members of “learned professions”¹⁹ (Dentists, MDs, DOs, Clergy, and Attorneys-at Law) may organize a Professional Limited Liability Company²⁰ (PLLC) or a Professional Services Corporation (PSC) to provide professional services. This forces APRNs to practice under the business license of a physician with whom a collaborative agreement (including payments to the physician) has been signed. APRNs must have separate definitions, licensure, independent practice, and direct reimbursement (see Recommendations 1a and 1c), accompanied by appropriate business licensure and permitting for establishment of a PLLC or PSC offering professional services; this will improve access to care for Michigan residents.²¹ ²²The United States Federal Trade Commission recently has issued opinions stating that removal of restrictions on APRN practice is pro-competitive and will improve access to care.²³ Until PLLC statute changes are made, Michigan will not attract APRNs as business owners and practitioners.

Also see TFNP Recommendation and Position Paper 9

Recommendation 1c - Direct Payment/Reimbursement for APRN Healthcare Services

To improve access to healthcare for Michigan residents, APRNs must be paid directly and appropriately for the high-quality healthcare services they provide. State Government should communicate to Michigan’s Congressional Delegation the urgency of aligning federal healthcare reimbursement systems to pay APRNs directly and appropriately. For example, State Government already acts as a model payer for Certified Nurse Practitioners, reimbursing them directly for Medicaid healthcare services. However, Certified Nurse Midwives²⁴ are severely restricted in the Medicaid billing codes that are payable; this

decreases patients' access to care.²⁵ All health insurers and payer organizations should fully reimburse all APRNs in Michigan.

Reasons for Recommendation 1c - APRNs provide high-quality, safe care in a wide range of healthcare locations. Currently, when billing certain payers, APRNs in Michigan can be reimbursed for their services only through a collaborative agreement with a licensed physician. In some cases, APRNs are not permitted to use payment codes that accurately describe the services provided. Forty years of research has shown that care provided by Certified Nurse Practitioners is equivalent to care provided by physicians.^{26 27} Certified Nurse Anesthetists have been found to provide anesthesia care equivalent to that of anesthesiologists in a direct comparison of patient outcomes and complications,²⁸ and to provide more cost effective care.²⁹ Compared to patients of physicians, patients of Certified Nurse Midwives experienced birth with fewer costly tests and surgeries, with comparable neonatal outcomes.³⁰ Clinical Nurse Specialists provide specialty care for people of all ages and in all healthcare locations; the outcomes for CNS practice include: improved patient functioning; decreased hospital length-of-stay; and reduced hospital readmission rates.³¹ APRNs have patient satisfaction scores that are consistently higher than those of other healthcare providers.^{32 33} APRNs should be reimbursed directly and appropriately for the healthcare services they provide.

Who Will Benefit from the Recommended Solution?

Implementation of the Recommendation will increase the number of APRNs providing safe, high-quality, effective healthcare in Michigan:

This will benefit the individuals, companies, and government agencies purchasing healthcare insurance and services for recipients of healthcare in Michigan, since a wider range and greater number of healthcare providers will be available to provide safe, high-quality healthcare. "Restrictions on APRN scope of practice threaten consumers' access to affordable, high quality care, health care that enhances quality of life and keeps employees in the workplace, a benefit to economic security and business productivity."³⁴ This will help to control the rate of increase of healthcare costs, which currently are growing at an average of 9% to 10% per year.³⁵

This will benefit all those who receive healthcare from Michigan APRNs in independent practice, since APRNs have been rated as providing care as good as or better than healthcare received from other healthcare providers in multiple studies.³⁶ Forty years of research has shown that care provided by Certified Nurse Practitioners is equivalent to care provided by physicians.^{37 38} Certified Nurse Anesthetists have been found to provide anesthesia care equivalent to that of anesthesiologists in a direct comparison of patient outcomes and complications,³⁹ and provide more cost effective healthcare.⁴⁰ Compared to patients of physicians, patients of Certified Nurse Midwives experienced birth with fewer costly tests and surgeries, with comparable neonatal outcomes.⁴¹ Clinical Nurse Specialists provide specialty care for people of all ages and in all healthcare locations; the outcomes for CNS practice include: improved patient functioning; decreased hospital length-of-stay; and reduced hospital readmission rates. APRNs have patient satisfaction scores that are consistently higher than those of other healthcare providers.^{42 43}

This will benefit the people of Michigan, whose access to high-quality healthcare will be positively impacted as the number of APRNs in Michigan increases.⁴⁴ Michigan communities are experiencing increased primary and specialty care shortages and as more individuals become insured (through Medicare, Medicaid, or the Health Insurance Exchange) this shortage will grow. In some rural communities, APRNs are the only practitioners providing primary, obstetrical, and anesthesia healthcare.⁴⁵ Current supervision requirements within the MPHC are making access to healthcare in

shortage areas more difficult.⁴⁶ Anesthesia services impact the availability and cost of many healthcare services. With equal quality of care outcomes, a CRNA's education costs 15% of the education of an Anesthesiologist.⁴⁷ Society will benefit as it costs less to increase the number of APRN providers compared to increasing the physician equivalent.

This will benefit the approximately 100,000 Michiganders who will reach age 65 every year for the next 20 years. Older populations generally use more healthcare services and have multiple chronic diseases.⁴⁸ The National Committee for Quality Assurance (NCQA) reported in 2010 that better management of chronic diseases such as diabetes, asthma and heart disease will become critical as the U.S. population ages.⁴⁹ Currently, 75 cents of every dollar spent in healthcare is spent on chronic diseases that are largely preventable.⁵⁰ APRNs have an excellent track record in preventing, diagnosing and managing the care of patients with multiple chronic diseases.⁵¹ Allowing APRNs to practice to the full extent of their required education and competencies will reduce healthcare costs for all parties.⁵²

This will benefit the people of Michigan and their healthcare providers, who will have more information, increased transparency and clarity in the regulation of APRNs; this factor also will contribute to safe, high quality healthcare and better communication between healthcare providers, particularly patients served by an inter-professional collaboration.^{53 54}

This will benefit other healthcare providers in Michigan (including physicians, hospitals, and others), who will benefit from the increase of APRN primary care and specialty care providers available to provide services during a period when demand greatly exceeds supply, particularly in shortage areas of the state.⁵⁵

This is consistent with Governor Snyder's Michigan 3.0 Vision and the Michigan Department of Community Health Strategic Priorities by increasing the number of APRNs available to provide access to care, and better care at lower cost. The strategic priorities of MDCH - 1) decrease infant mortality and 2) decrease obesity - will be supported by APRNs working in primary care, specialty care, community-based care, and health systems improvement, practicing to the full extent of their required education and competencies to prevent disease, promote health, and improve care.⁵⁶

Background: Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP was composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP will meet through April 2012; however, the issue of Improving practice for Advanced Practice Registered Nurses is high priority, urgent, and timely for improving access to health care for Michigan residents. ***Therefore, this Recommendation and associated Position Paper were approved by the MDCH-Task Force on Nursing Practice on June 13, 2011 and forwarded to the Director of MDCH.***

Appendix A – Recommended Definitions

Advanced Practice Registered Nurse (APRN) - A registered nurse who holds second licensure in one of the current⁵⁷ APRN roles [Clinical Nurse Specialist, Certified Nurse Anesthetist, Certified Nurse Midwife, and Certified Nurse Practitioner] by virtue of additional knowledge and skills gained through an advanced formal education program of nursing that has national nursing accreditation. This advanced formal education program of nursing in one of the four APRN roles shall result in a minimum of a nursing master's degree, a post-nursing-master's-degree specialty certificate, or a nursing doctorate.⁵⁸ APRNs also must meet the certification requirements of appropriate national nursing certification bodies.

Certified Nurse Anesthetist - A registered nurse who holds second licensure as a Certified Nurse Anesthetist who provides the full spectrum of anesthesia care and anesthesia-related services for individuals across the lifespan and in all healthcare locations.

Certified Nurse Midwife - A registered nurse who holds second licensure as a Certified Nurse Midwife who provides a full range of primary care services for women throughout their lifespan, including comprehensive maternity and newborn care, and treatment of male partners for sexually transmitted infection and reproductive health.

Certified Nurse Practitioner - A registered nurse who is licensed as a Certified Nurse Practitioner who provides: comprehensive assessments, screening, diagnosing, treating, and managing patients with acute and chronic illnesses and diseases; health promotion; disease prevention, health education, and counseling of patients and families with potential, acute, and chronic health disorders.

Clinical Nurse Specialist - A registered nurse who is licensed as a Clinical Nurse Specialist who provides specialized programs of healthcare for acute and chronically ill patients and their families. Within healthcare systems, CNSs lead and direct evidence-based care and care-system-improvement programs that strengthen the quality, safety, and cost effectiveness of the healthcare provided to the public.

Appendix B – Case Statement for Inclusion of Clinical Nurse Specialists in Michigan Regulation of Advanced Practice Registered Nurses (APRN)

For the health and safety of the people of Michigan, we must regulate the Clinical Nurse Specialist (CNS) role of Advanced Practice Registered Nurses (APRNs) in the manner proposed in this TFNP Position Paper for all APRNs. The CNS role must be included in proposed changes to the Michigan Public Health Code (MPHC) and in any related legislation.

1. When specialty certification for APRN roles was added to the MPHC 33 years ago, the CNS role was overlooked. Since it was not possible to receive specialty certification as a CNS, some CNS practitioners have chosen to be certified as Nurse Practitioners, but many have not. The CNS role is not the same as the Nurse Practitioner role, and over the past 33 years, the role differences have become stronger.
2. Most CNSs have been invisible to the Michigan regulatory system for the past 33 years, but are practicing under their master's degrees and national certifications in healthcare systems (hospitals, community-based health centers, home health, and long term care) across the state.
3. To further complicate the situation, some employers of nurses in Michigan have created the employment category "Clinical Nurse Specialist" for experienced Registered Nurses (RNs) working in a specialty area.⁵⁹
4. Since educated and credentialed CNSs have been invisible to Michigan regulators, there is little reliable statistical information about them. Informal estimates range from 200 to 300 CNSs in Michigan. Out of 55 states and territories surveyed, twenty-four states and territories recognize CNSs as an APRN category; an additional 17 states and territories recognize Psychiatric CNSs. Thirty-four of these jurisdictions also authorize prescriptive authority for CNSs.
5. It is not logical to perpetuate an error made 33 years ago; we must correct that error and bring the APRN role of Clinical Nurse Specialist into the group of APRN roles in Michigan – regulating them as other APRN roles are regulated.
6. "The CNS is an expert clinician in a specialized area of nursing practice...CNSs are engaged in direct clinical practice; function as consultants in their area of expertise; provide expert coaching and guidance; and interpret, evaluate, and participate in research."⁶⁰
7. CNSs improve the quality of care for all patients by analyzing the systems that provide care, then planning and directing programs to improve the quality of care and make it more consistent. These are important nursing activities; and as federal pay-for-performance initiatives affect hospitals and clinics, the education and competencies of CNSs will become even more important than they are at present.
8. The continuing risks associated with not regulating CNSs are that Michigan regulators will not have information about them or be able to monitor them as these health professionals become: a) more and more significant in the provision of care to elderly patients with complex chronic diseases, and b) increasingly engaged in the analysis and evaluation of healthcare systems as Michigan's share of national healthcare funding becomes dependent upon success in providing better care at lower cost.
9. CNSs have significant effects on the functioning of the healthcare system in Michigan. Categories of health professionals with significant effects on the healthcare system of the state – and therefore on the health and safety of the public – are regulated by State Government.
10. The regulation of CNSs will increase the work of the MDLARA Bureau of Health Professions. CNSs anticipate that special review fees may be necessary to implement the second licensure of their role and to "grandfather" some CNSs into the APRN category, since the CNS role has not been part of the regulatory system for the past 33 years.

End Notes

¹ This definition is based on the Consensus Model for APRN Regulation referenced in End Note 3. The addition of “and/or certification,” is based on the current situation in Michigan, where APRNs do not have second licensure, but may apply for a specialty certificate from the Michigan Bureau of Health Professions – Michigan Board of Nursing. For TFNP recommended definitions, see Appendix A of this Position Paper.

² As additional Advanced Practice Registered Nurse (APRN) roles are recognized at the national level, the Michigan Bureau of Health Professions -- Michigan Board of Nursing should have authority to add these roles to the APRN category, treating them as other APRNs are treated.

³ APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee, (2008). *Consensus Model for APRN regulation: Licensure, accreditation, certification & education*. Retrieved March 11, 2011 from <http://www.aanp.org/NR/rdonlyres/56292A59-8240-449D-910D-EF331FC7DC86/0/FinalAPRNJointDialogueReport7708.pdf>

⁴ US Census, 2010. Results for Michigan.

⁵ 2011 Pearson Report – ranking of states as APRN practice environments. See citation below.

⁶ 2011 Pearson Report, Summary Table. *American Journal for Nurse Practitioners*. Downloaded from <http://www.pearsonreport.com/tables-maps/category/2011-summary-table/>. The Pearson Report annually provides a detailed review of the state factors supporting and constraining APRN practice. A state grade of “A” indicates that APRNs have independent practice with few or no restrictions. A state grade of “F” indicates that APRNs have no independent practice and are highly constrained. Grades B, C, & D indicate increasing degrees of constraint on APRN practice.

States/Districts graded “A” are Alaska, Arizona, Colorado, District of Columbia, Maine, Maryland, Montana, New Hampshire, New Mexico, Oregon, Rhode Island, Washington, & Wyoming.

States graded “B” are Connecticut, Hawaii, Idaho, Iowa, Kentucky, New Jersey, New York, & Utah.

States graded “C” are California, Delaware, Kansas, Minnesota, Mississippi, Nevada, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Vermont, West Virginia, & Wisconsin.

States graded “D” are Arkansas, Illinois, Indiana, Louisiana, Massachusetts, Nebraska, South Dakota, Texas, & Virginia.

States graded “F” are Alabama, Florida, Georgia, Michigan, Missouri, North Carolina, & South Carolina.

⁷ *Ibid*.

⁸ Access to Care and Advanced Practice Nurses. (2010) *American Association of Retired Persons and Robert Wood Johnson Foundation*.

⁹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Michigan is not an APRN “friendly” state. Graduates are moving out of state at a time when more primary care providers are needed in Michigan. Eliminating unnecessary barriers to practice would encourage more APRN graduates to stay in Michigan and provide primary care to Michigan’s residents. State restrictions on APRN practice are not evidence based and do not increase patient safety. Abolishing these restricting regulations would increase the amount of primary care providers practicing in Michigan, and increase access to care in a cost effective manner.

¹⁰ Barkauskas, VH, JM Pohl, C Tanner, & B Pilon. (2011). Quality of Care in Nurse-Managed Health Centers. *Nursing Administration*, 35, No 1, pp 34-43.

¹¹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: All four roles of APRNs are lacking a definition and a well-defined scope of practice in the MPH. Consequently, the abilities and competencies of APRNs are often misunderstood by the public and other healthcare professionals. By clearly defining the scope of practice of all four APRNs roles, APRNs can educate the public and professional communities in a “manner that is consistent and enlightening.” These steps will advance the practice of APRNs in a time when there is a shortage of healthcare providers. APRNs provide comprehensive, evidence-based, high-quality care that is cost effective. Defining the scope of practice for APRNs will: increase safety for patients and providers, decrease public and provider discrimination against APRNs based on lack of knowledge of APRNs practice credibility, and decrease the healthcare provider shortage.

¹² “The Future of Nursing: Leading Change, Advancing Health.” (2010). *Institute of Medicine and Robert Wood Johnson Foundation*.

¹³ The Director of the Michigan Department of Community Health (MDCH) should recommend to the Director of the Michigan Department of Licensing and Regulatory Affairs (MDLARA) that specific provisions and procedures be instituted to “grandfather” CNSs into the APRN category.

¹⁴ Abstract of a Nursing Practice Issue Statement Received by the TFNP: A CNS, who graduated before 2007 from an accredited master’s or doctoral nursing program including preparation as a CNS, may not be eligible to take the CNS national certification examination. Such experienced CNSs require an alternative certification mechanism through the State Board of Nursing; this may include an externally evaluated portfolio of evidence that demonstrates knowledge and skill competence in

the CNS role. The American Nurses Credentialing Center (ANCC) instituted the 2007 requirement for core competencies and 500 clinical practice hours in a master's or doctoral nursing program; the ANCC or a Michigan Expert Panel would be appropriate external reviewers of CNS portfolios submitted to the MBON.

¹⁵ For example, some employers of nurses in Michigan have created the employment category "Clinical Nurse Specialist" for Registered Nurses with several years of experience in a specialty area (such as Intensive Care). When all four roles of APRNs have definitions, title protection, and second licensure, this type of employment category must be re-named.

¹⁶ Individuals granted "Specialty Certification" (or any other equivalent certification) by the MBON and who met the requirements for certification at the time of certification, and have continued to practice under that certification should be "grandfathered in" to the definitions of all four roles of APRNs.¹⁶ This would allow already practicing APRNs and MBON certified practitioners to continue to practice. This solution would allow APRNs and MBON certified practitioners to continue to provide excellent care to patients in Michigan at a time when more providers are needed.

¹⁷ Michigan Limited Liability Company Act, Section 904: 1993 PA 23, MCL 450.4904

¹⁸ 2011 Pearson Report – ranking of states as APRN practice environments.

¹⁹ "Services in a learned profession" is defined in section 102(2) (s) of the Michigan Limited Liability Company Act as "services rendered by a dentist, an osteopathic physician, a physician, a surgeon, a doctor of divinity or other clergy, or an attorney-at-law."

²⁰ Michigan Limited Liability Company Act, Section 904: 1993 PA 23, MCL 450.4904; administered by the Bureau of Commercial Services, Michigan Department of Licensing and Regulatory Affairs.

²¹ Buppert, C. (2008). *Nurse practitioner's business practice and legal guide*, 3rd ed.

²² Abstract of a Nursing Practice Issue Statement Received by the TFNP: New federal programs have put a major emphasis on coordination of care – so that tests are not duplicated and the right care is provided at the right time by the most appropriate care provider – and APRNs have demonstrated that they are excellent providers of care coordination.²²

²³ United States of America. Federal Trade Commission. Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Florida House Bill 4103 (2006). 2011. <http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf>

United States of America. Federal Trade Commission. Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Texas Senate Bill 1260 and 1339. 2011. <http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf>

²⁴ Abstract of a Nursing Practice Issue Statement Received by the TFNP: The coding for the current Medicaid reimbursement system for Certified Nurse Midwives (CNMs) in Michigan is out of compliance with the Federal Register. The reimbursement structure in Michigan restricts CNMs to specific codes that do not cover the services provided. Therefore, CNMs either must bill inaccurately for services, or not bill at all. Without regulatory or legislative changes, access to care will continue to decline due to poor reimbursement for CNMs.

²⁵ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Michigan's Certified Nurse Midwives (CNM) Medicaid reimbursement system is out of date with Federal regulations. CNMs E and M codes are limited to levels one and two out of five (99201, 99202, 99211, and 99212). These codes do not cover all the services provided by CNMs. CNMs either under-code or do not code at all; therefore the CNMs reimbursement system does not cover the services provided. The majority of the care provided by CNMs is at level three or four and CNMs cannot be reimbursed at these levels. In order to allow CNMs to appropriately bill for services, the Medicaid reimbursement system for CNMs should be changed to match that of Nurse Practitioners -- an open billing system.

²⁶ Mundinger MO, Kane RI, Lenz ER, et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians. *Journal of the American Medical Association*.283:59-68.

²⁷ Lenz ER, Mundinger MO, Kane RI, et al. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow. *Med Care Res Rev*, 61:332-51.

²⁸ Dulisse, B and Cromwell, J. (2010). No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians. *Health Affairs*, 29, no.8: 1469-1475. See <http://content.healthaffairs.org/content/29/8/1469.full.html>.

²⁹ Hogan, P., Seifert, RF., Moore, C. Simonson, B. (2010). Cost Effectiveness Analysis of Anesthesia Providers. *Nursing Economics*, 28(3): 159-169.

³⁰ Cragin, L., and Kennedy, H. (2006). Linking Obstetric and Midwifery Practice with Optimal Outcomes. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*.

³¹ Lewandowski, W., Adamle, K. (2009). Substantive Areas of Clinical Nurse Specialist Practice: A Comprehensive Review of the Literature. *Clinical Nurse Specialist*, 23(2): 73-90.

³² Laurant M., Reeves D., Hermens R., et al (2005).Substitution of doctors by nurses in primary care. *Cochrane Database Syst Rev*, 18:CD001271.

³³ Mundinger MO, *op cit*

-
- ³⁴ American Association of Retired Persons (AARP) and Robert Wood Johnson Foundation (RWJF). (2010). Access to Care and Advanced Practice Nurses.
- ³⁵ Kaiser Family Foundation. (2010). *State Health Facts*.
- ³⁶ Munding MO, *op cit*.
- ³⁷ Munding MO, Kane RI, Lenz ER, et al. (2000). Primary care outcomes in patients treated by nurse practitioners or physicians. *JAMA*, 283:59-68.
- ³⁸ Lenz ER, Munding MO, Kane RI, et al. (2004). Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow. *Med Care Res Rev*, 61:332-51.
- ³⁹ Dulisse, B., and Cromwell J., *op cit*.
- ⁴⁰ Hogan, P., Seifert, RF., Moore, C. Simonson, B. *op cit*.
- ⁴¹ Cragin, L., and Kennedy, H. *op cit*.
- ⁴² Laurant M., Reeves D., Hermens R., et al. *op cit*.
- ⁴³ Munding MO, *op cit*
- ⁴⁴ Horricks, S., Anderson, E., and Salisbury, C. (2002). Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors. *British Medical Journal*, 819-823.
- ⁴⁵ American Association of Retired Persons (AARP) and Robert Wood Johnson Foundation (RWJF), *op cit*.
- ⁴⁶ The Institute of Medicine and Robert Wood Johnson Foundation. (2010). *The Future of Nursing: Leading Change, Advancing Health*.
- ⁴⁷ Hogan, P. *op cit*
- ⁴⁸ Fairman, J. Rowe, J. Hassmiller, S & Shalala, D. (2011). Broadening the Scope of Nursing Practice. *The New England Journal of Medicine*, 364, 193-195.
- ⁴⁹ Bielaszka-DuVernay, C. (2011). Improving Quality and Safety. *Health Affairs and Robert Wood Johnson Foundation*.
- ⁵⁰ Thorpe, K., and Lever, J., (2011). Prevention: The Answer to Curbing Chronically High Health Care Costs. *Kaiser Health News*.
- ⁵¹ Bielaszka-DuVernay, C. *op cit*.
- ⁵² Barkauskas, V., *op cit*.
- ⁵³ Susman, J. MD. (2010). It's time to collaborate-not compete with NPs. *Journal of Family Practice*, 59, 672.
- ⁵⁴ O'Grady, E., (2008). Lack of Collaboration, Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality. Agency for Healthcare Research and Quality, Patient Safety and Quality: an Evidence-Based Handbook for Nurses. www.ahrq.gov/qual/nursesfdbk/
- Cowan MS, Hays, RD. (2006). The Effect of a Multidisciplinary Hospital/Physician and Advanced Practice Nurse Collaboration on Hospital Costs. *Journal of Nursing Administration*. 36(2): 79-85.
- ⁵⁵ Access to Care and Advanced Practice Nurses. (2010). American Association of Retired Persons (AARP) and Robert Wood Johnson Foundation (RWJF).
- ⁵⁶ O'Grady, E. *op cit*.
- ⁵⁷ As additional Advanced Practice Registered Nurse (APRN) roles are recognized at the national level, the Michigan Bureau of Health Professions-Michigan Board of Nursing should have authority to add these roles to the APRN category, treating them as other APRNs are treated.
- ⁵⁸ *Consensus Model for APRN regulation: Licensure, accreditation, certification & education*. (2008). Advanced Practice Registered Nurse (APRN) Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee. Retrieved March 11, 2011 from <http://www.aanp.org/NR/rdonlyres/56292A59-8240-449D-910D-EF331FC7DC86/0/FinalAPRNJointDialogueReport7708.pdf>
- ⁵⁹ Currently Michigan has people working under the title Clinical Nurse Specialist who are not educated for or credentialed in this role, and do not meet national standards. Employers of nurses have used the title as an RN employment category.
- ⁶⁰ O'Grady, E. (2010). Chapter 43. Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality. Agency for Healthcare Research and Quality, Patient Safety and Quality: an Evidence-Based Handbook for Nurses.

This page intentionally left blank

MDCH – Task Force on Nursing Practice – Position Paper 2

Modernize Registered Nurses’ Scope and Standards of Practice

Recommendation: To improve access to healthcare for Michigan residents, statutory and regulatory changes must be made so that all Registered Nurses (RNs) in Michigan are able to practice to the full extent of their required education and competencies.

Summary of Issue

Demand for healthcare services is increasing and will continue to rise as Michigan’s percentage of residents over age 65 grows.¹ Older people have more chronic health conditions and use more healthcare services. In addition, health insurance changes are expected to shift approximately 1.5 million persons from “uninsured” to “insured” in Michigan by 2015, further increasing healthcare demand. Registered Nurses are the largest group of health care professionals (there are over 141,000 Registered Nurses in Michigan),² providing care in a wide range of settings.³ Registered Nurses (RNs) are critical to the health and safety of the residents of Michigan. However, the title “Nurse” is not included in the list of protected titles.⁴ Consequently, the residents of Michigan cannot be assured that the person using the title of Nurse has the education and competencies to practice as a Registered Nurse. The availability of healthcare and access to care in Michigan has been restricted by statutes and regulations on nurses’ scope of practice.

Access to healthcare will become increasingly restricted for Michigan residents if RNs are not practicing to the full extent of their required education and competencies. Barriers to nursing scope of practice inflate the cost of healthcare and decrease access to care.⁵ For example, many patients discharged from hospitals are re-hospitalized within a month of discharge, an expensive failure to coordinate community-based care with hospital care. The hospital RNs who cared for the patient and talked with their family should be empowered - in consultation with the care team and following applicable regulations - to make pre-discharge referrals to home healthcare services in the patient’s community, ensuring that patients and families have the coordinated care and community resources that they need. This nursing referral process would be more efficient than the current system.

Summary of Solution

To improve Michigan residents’ access to high-quality, safe healthcare, the State of Michigan must remove the statutory and regulatory barriers that keep Registered Nurses from practicing to the full extent of their required education and competencies.⁶ In recognition of RNs’ education, qualifications, and vital roles in patient care, nurses should have title protection (see Appendix A). The 2010 Institute of Medicine (IOM) report *The Future of Nursing* concluded that ***all nurses should practice to the full extent of their education and training***. This conclusion is reinforced by the dynamic nature of the healthcare practice environment and the growing demand for healthcare that is patient-centered, coordinated, and delivered in the community and patient homes. Healthcare must be provided seamlessly across all health conditions, settings and providers.⁷ Nurses are uniquely qualified to provide patient-centered, evidence-based care, and care coordination across all healthcare settings, to improve the outcomes of care. Thus, it is essential for access to care and for the health and safety of the public - that scope of nursing practice (as stated in the most recent American Nurses Association *Scope and Standards of Practice*) is explicitly included in the Michigan Public Health Code as the basis for decision-making with respect to nursing scope of practice.

Recommended Definitions

The Practice of Nursing is the systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition.^{8 9} Nursing is a profession that is

evidence-based, requires an understanding of the human condition, and applies the current science of professional caring^{10 11 12} to health goals mutually established with patients.

Scope of Practice for Registered Nurses¹³ - The complete Scope of Practice for Registered Nurses is stated in the most recent edition of the *Nursing Scope and Standards of Practice* of the American Nurses Association. The profession of nursing (Registered Nurses)¹⁴ has one scope of practice that encompasses the full range of nursing practice, pertinent to general and specialty practice. The individual registered nurse's ability to engage in the total scope of nursing practice is dependent on their required education, competency, experience, role, and the population served.¹⁵ The authority for nursing is based on a social contract and relationship with the public.¹⁶ Nursing is a dynamic discipline that increasingly involves more extensive knowledge, technologies and patient care activities.¹⁷

Sub-Recommendations and Reasons

Recommendation 2a - Title Protection for "Nurse"

To improve healthcare quality and safety for Michigan residents, State Government must include protection for the title "Nurse" in the Michigan Public Health Code (MPHC) and the Administrative Rules of the Michigan Board of Nursing (MBON). "Nurse" should be understood by the public as a guarantee of appropriate nursing education, specialized knowledge, assured competencies, and Registered Nurse licensure. The MPHC should define and protect the title as follows: "nurse, *when used without modification or amplification, means only a registered nurse.*"¹⁸

Reasons for Recommendation 2a - Protection for the title "Nurse" is essential for consumer understanding and confidence in the role of nurses. At present, the MPHC protects the term Registered Nurse and RN. Just as the titles "Physician," "Dentist," "Chiropractor," and "Social Worker" are protected by the MPHC, the title "Nurse" should also be protected. Currently, the title "Nurse" may be used (and is used) by persons with no nursing education or licensure, thereby confusing the public. Nurses provide a great deal of the healthcare received nationally and therefore are key professionals, responsible for the protection, promotion, and improvement of the health of the public. When a person identifies themselves as a Nurse, the patient and/or their family should be assured and confident that the Nurse has the required education and competencies of a RN. At least 30 States are currently known to have statutory protections for the term "nurse." The Michigan Public Health Code should also define and protect the title "nurse."

Recommendation 2b - Nursing Scope of Practice

To improve the quality and safety of healthcare for Michigan residents, State Government must make changes in the Michigan Public Health Code (MPHC) and the Michigan Board of Nursing (MBON) Administrative Rules to adopt and utilize the Scope of Nursing Practice as it is stated in the most recent edition of the American Nurses Association (ANA) *Scope and Standards of Practice*.^{19 20} This also will improve public and professional awareness of the ANA standards and scope of practice, providing a national professional standard for decision-making.²¹

Reasons for Recommendation 2b - The roles and abilities of Registered Nurses are frequently misunderstood by the public and health care professionals, who are unaware of national nursing standards. Nursing is a dynamic discipline, continuously evolving and expanding as more sophisticated knowledge and new technologies are developed.²² The MPHC needs to reflect our rapidly changing healthcare system²³ by ensuring that RNs have a scope of practice that is flexible and capable of evolving with the needs of the practice environment. This can be accomplished by recognizing and adopting the most recent edition of the ANA *Scope and Standards of Practice* as the basis for *competent* Nursing Practice. The ANA standards are statements regarding the duties of all nurses regardless of role, population served, or

specialty.²⁴ The health profession of nursing defines its' practice at the national level. The MBON should establish as a policy the utilization of the most recent ANA standards in all decisions regarding nursing practice. This will inform the public and all healthcare professionals about the education and competencies of Registered Nurses.

Recommendation 2c - Nurse Licensure Compact

To improve access to healthcare for Michigan residents, State Government must make changes in the MPHIC and the MBON Administrative Rules to become part of the national Nurse Licensure Compact (NLC) for Registered Nurses. The Compact is an interstate agreement (currently 27 states have joined the Compact) established for the purpose of allowing Registered Nurses (RNs) to practice physically and electronically across state lines.

Reasons for Recommendation 2c - Adopting the Nurse Licensure Compact will make Michigan a more attractive environment for the establishment and growth of emerging healthcare technology businesses. The Nurse Licensure Compact improves the ability of RNs to offer electronic consultation and case management services in more than one state. Telehealth arrangements in which RNs in one state provide nursing consultation to patients in many states are increasing, and are seen as an efficient mode of care. Increasing numbers of patients are receiving professional nursing services electronically for care coordination and prevention of complications from chronic diseases. RNs are able to assess, evaluate and initiate interventions that can prevent further complications and reduce or prevent re-hospitalizations. This in turn decreases the cost of health care services. Having more nurses available to work in Michigan through participation in the Nurse Licensure Compact will increase access to healthcare for Michigan residents and improve Michigan's economy.

When an RN changes his/her primary state of residency by moving from one compact state to another compact state, the nurse can practice on the former residency license for up to 30 days (after employer standards are met with respect to background checks and other safeguards). The RN is required to apply for licensure by endorsement, pay any applicable fees and complete a declaration of primary state of residency in the new home state, whereby a new multistate license is issued and the former license is inactivated. Having the ability to practice for a Michigan employer immediately for 30 days when moving into the state would substantially increase the number of RNs available to provide nursing care to Michigan residents. Not only does Nursing Licensure Compact increase access to healthcare, it also is an incentive that attracts qualified Registered Nurses to Michigan.²⁵

Other Recommendations that include a Nursing Scope of Practice Component - Please see TFNP Position Papers 1-8: Improve Practice for Advanced Practice Registered Nurse (APRN); Clarify Delegation of Nursing Functions; Delineate the Practice and Role of Licensed Practical Nurses; Update Regulation of Nursing Assistive Personnel (NAPs);^{26 27} Increase Practice Efficiencies in Nursing & Healthcare; and Advance Technology in Nursing Practice and Healthcare.

Who Will Benefit from the Recommended Solution?

This solution will benefit the people of Michigan, whose access to high-quality, safe healthcare will be positively impacted as those practicing under the title of "nurse" will be required to have appropriate nursing education, specialized knowledge, and assured competencies. When a person identifies themselves as a Nurse, the patient and/or their family should be assured and confident that the Nurse has the required education and competencies of a RN.

This solution will benefit the people of Michigan, whose access to high-quality healthcare will be positively impacted as the number of Michigan RNs practicing to the full extent of their required

education and competencies increases. Michigan's rural areas are experiencing increased healthcare shortages and when more individuals become insured this shortage will only increase. In addition, we expect 100,000 Michiganders to turn age 65 every year for the next 10-20 years, requiring more healthcare and more coordinated care. The trend is towards more health care in community or home settings; these less-structured care settings need RNs to assure patient safety and provide patient-centered, evidence based care, and lead care coordination.²⁸ Evidence has shown that the greatest potential for errors and harm occurs when the transition from one level of care to another is not communicated effectively. Care coordination must be patient-centered and provide comprehensive information to the next level of care provider. Nursing referral process involving the entire care team can provide an opportunity for comprehensive communication regarding care needs. Organizational discharge processes and collaboration of the health care team can support more efficient and safe care to patients/clients and their families. Efficiency can be further improved by ensuring that health care personnel are used in a way that makes the most of their capabilities. Nurses who are able to practice to the full extent of their required education and competencies can improve the safety of care coordination, especially for an aging population.²⁹

This solution will benefit the economy of Michigan. Adopting the Nurse Licensure Compact will make Michigan a more attractive environment for the establishment and growth of emerging healthcare technology businesses. The Nurse Licensure Compact improves the ability of nurses to offer electronic consultation and case management services in more than one state. Telehealth arrangements in which nurses in one state provide nursing consultation to patients in many states are increasing, and are seen as an efficient mode of care. RNs are able to assess, evaluate and initiate interventions that can prevent further complications and reduce or prevent re-hospitalizations, decreasing the cost of healthcare. Having more nurses available to work in Michigan through participation in the Nurse Licensure Compact will increase access to healthcare for Michigan residents and improve Michigan's economy.

This solution will benefit the individuals, companies, and government agencies purchasing healthcare insurance and services for recipients of healthcare in Michigan, since nurses will be practicing to the full extent of their required education and competencies, and will be available to provide safe, high-quality healthcare. For example, many patients discharged from hospitals are re-hospitalized within a month of discharge, an expensive failure to coordinate community-based care with hospital care. The hospital RNs who cared for the patient and talked with their family should be empowered – in consultation with the care team and following applicable regulations - to make pre-discharge referrals to home healthcare services in the patient's community, ensuring that patients and families have the coordinated care and community resources that they need. This nursing referral process would be more efficient and effective than the current system.

This solution will benefit the people of Michigan and their healthcare providers, who will have more information, increased transparency and clarity in the regulation of nursing titles, scope of practice, and functions; this factor also will contribute to safe, high quality healthcare and better communication between healthcare professionals.³⁰ In addition, during a period when demand for healthcare will greatly exceed supply (particularly in shortage areas of the State), healthcare providers will benefit from nurses' ability to practice to the full extent of their required education and competencies.³¹

Background: Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing

practice, thereby protecting the health and safety of Michigan residents. The TFNP is composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met for the first time in December 2010 and continues through April 2012 to gather information, consult with state and national experts in nursing practice and policy, and consider issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue Modernizing Registered Nurses' Scope and Standards of Practice has been determined by the TFNP to be of high priority.

Appendix A – Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

“Nurse,” when used without modification or amplification, means only a registered nurse.³² [MPHC 333.17201]

Practice of Nursing - The systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition.^{33 34} Nursing is a profession that is evidence-based, requires an understanding of the human condition, and applies the current science of professional caring^{35 36 37} to health goals mutually established with patients. [MPHC 333.17201]

Scope of Practice for Registered Nurses³⁸ - The complete Scope of Practice for Registered Nurses is stated in the most recent edition of the Nursing Scope and Standards of Practice of the American Nurses Association. The profession of nursing (Registered Nurses)³⁹ has one scope of practice that encompasses the full range of nursing practice, pertinent to general and specialty practice. The individual registered nurses’ ability to engage in the total scope of nursing practice is dependent on their required education, competency, experience, role, and the population served.⁴⁰ The authority for nursing is based on a social contract and relationship with the public.⁴¹ Nursing is a dynamic discipline that increasingly involves more extensive knowledge, technologies and patient care activities.⁴² [MPHC 333.17201]

Title Protection

The following words, titles, or letters or a combination thereof, with or without qualifying words or phrases are restricted in use only to those persons authorized under this part to use the terms and in a way prescribed in this part: “**nurse**,” “registered professional nurse,” “registered nurse,” “r.n.,” “licensed practical nurse,” “l.p.n.,” “certified nurse midwife,” “certified nurse anesthetist,” “certified nurse practitioner,” “**clinical nurse specialist**.”⁴³ [MPHC 333:17211]

Appendix B – American Nurses Association Scope and Standards of Practice, 2010 Major Elements

“Significance of Standards

“The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently. The standards published herein:

- May be utilized as evidence of the standard of care, with the understanding that application of the standards is context dependent.
- Are subject to change with the dynamics of the nursing profession, as new patterns of professional practice are developed and accepted by the nursing profession and the public, and
- Are subject to formal, periodic review and revision.”⁴⁴

“Standards of Professional Nursing Practice”⁴⁵

- Standard 1. Assessment
- Standard 2. Diagnosis
- Standard 3. Outcomes Identification
- Standard 4. Planning
- Standard 5. Implementation
- Standard 6. Evaluation”

“Standards of Professional Performance”⁴⁶

- Standard 7. Ethics
- Standard 8. Education
- Standard 9. Evidence-Based Practice and Research
- Standard 10. Quality of Practice
- Standard 11. Communication
- Standard 12. Leadership
- Standard 13. Collaboration
- Standard 14. Professional Practice Evaluation
- Standard 15. Resource Utilization
- Standard 16. Environmental Health”

Nursing Scope and Standards of Practice, 2nd Edition. American Nurses Association, 2010. This book is published by Nursesbooks.org and available at www.nursesbooks.org.

End Notes

- ¹ *Occupational Regulation Sections of the Michigan Public Health Code*: MDCH Authority: P.A. 368 of 1978 as amended.
- ² This data includes Registered Nurses and Advanced Practice Registered Nurses and reflects Michigan Department of Licensing and Regulatory Affairs: Bureau of Health Professions data from August 2011.
- ³ Michigan Center for Nursing. (2010). *Survey of Nurses*.
- ⁴ Section 172 Michigan Public Health Code. P.A. 368 of 1978, as amended.
- ⁵ LeBuhn, Rebecca, et al. (2010). Reforming Scopes of Practice. *Citizens Advocacy Center*.
- ⁶ LeBuhn *op cit*
- ⁷ The Institute of Medicine and Robert Wood Johnson Foundation. (2010). *The Future of Nursing: Leading Change, Advancing Health*.
- ⁸ *Occupational Regulation: Michigan Public Health Code, op cit*.
- ⁹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition.
- ¹⁰ Watson, Jean. (2008). *Nursing: The Philosophy and Science of Caring*. University Press of Colorado.
- ¹¹ Watson defines nursing “as a human science of persons and human health – illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (1988b, p. 54). In addition, she also views nursing as both a science and an art. Watson, J. (1988b). *Nursing: Human science and human care. A theory of nursing* (2nd printing). New York: National League for Nursing. (Original work published in 1985).
- ¹² Kolcaba, Katharine. (2002). *The Comfort Theory and Practice*. Springer.
- ¹³ The Scope of Practice for Registered Nurses is defined in the Michigan Public Health Code. The scope of practice for RNs may not be expanded by employers; however, employers may narrow the scope of practice for RNs either through policies or employee/labor agreements with entities, such as unions.
- ¹⁴ In this document, Scope of Practice should be understood to refer to the practice of Registered Nurses.
- ¹⁵ American Nurses Association, *op cit*.
- ¹⁶ American Nurses Association . (2010). *Nursing’s Social Policy Statement*.
- ¹⁷ National Association of State Boards of Nursing. (2009). *NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules*.
- ¹⁸ State of Wisconsin laws: Chapter 441. Subchapter I, Regulation of Nursing. 441.001 Definitions.
- ¹⁹ In this document, the *Nursing Scope and Standards of Practice* (2010) of the American Nurses Association will henceforth be referred to as the ANA Standards.
- ²⁰ The American Nurses Association publication, *Nursing Scope and Standards of Practice* (2010) is outlined in Appendix B.
- ²¹ To ensure that nursing scope of practice in the MPHC and the MBON Rules is updated with national standards, reference should always be made to the most recent edition of the ANA *Nursing Scope and Standards of Practice*. In 2011, the most recent edition is that of 2010.
- ²² American Nurses Association (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition.
- ²³ Abstract of a Nursing Practice Issue Statement received by the TFNP: Current state regulations are outdated and do not reflect the practice of registered nurses today. Practice as a Registered Nurse means the full scope of nursing, with or without compensation or personal profit, that incorporates caring for all clients in all settings, and is guided by National Standards of Nursing Practice
- ²⁴ American Nurses Association, *op cit*.
- ²⁵ Initial issues with respect to the Nurse Licensure Compact have been removed or resolved.
- ²⁶ The position paper *Regulatory Status of LPNs and UAPs* is concerned with LPNs and UAPs who are carrying out nursing functions delegated and supervised by RNs. The position paper provides a framework for appropriate supervision, consistent scope of practice, and responsibility for LPNs and UAPs.
- ²⁷ Licensure definitions and policies may conflict with organizational policies, and in some cases with negotiated contracts.
- ²⁸ Bielaszka-DuVernay, Christina. (2010). Improving Quality and Safety. *Health Affairs and Robert Wood Johnson Foundation*.
- ²⁹ The Institute of Medicine. (2008). *Retooling for an Aging America: Building the health care workforce*. Washington DC: The National Academies Press.
- ³⁰ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit*.

-
- ³¹ Rosen, Lawrence. (2010). Health Care Workforce in Michigan 2010-2020. *Health Care Workforce Advisory Roundtable, Public Policy Associates, Inc.*
- ³² State of Wisconsin Laws, *op cit.*
- ³³ Michigan Public Health Code, *op cit.*
- ³⁴ American Nurses Association, *op cit.*
- ³⁵ Watson, *op cit.*
- ³⁶ Watson defines nursing “as a human science of persons and human health—illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (1988b, p. 54). In addition, she also views nursing as both a science and an art. *Watson, J. (1988b). Nursing: Human science and human care. A theory of nursing* (2nd printing). New York: National League for Nursing. (Original work published in 1985.)
- ³⁷ Kolcaba, *op cit.*
- ³⁸ The Scope of Practice for Registered Nurses is defined in the Michigan Public Health Code. The scope of practice for RNs may not be expanded by employers; however, employers may narrow the scope of practice for RNs either through policies or employee/labor agreements with entities, such as unions.
- ³⁹ In this document, Scope of Practice should be understood to refer to the practice of Registered Nurses.
- ⁴⁰ American Nurses Association, *op cit.*
- ⁴¹ *Nursing’s Social Policy Statement*. (2010). American Nurses Association.
- ⁴² National Council of State Boards of Nursing, *op cit.*
- ⁴³ Section 172 Michigan Public Health Code. P.A. 368 of 1978, as amended.
- ⁴⁴ American Nurses Association. (2010). *Nursing Scope and Standards of Practice*. p. 31.
- ⁴⁵ *Ibid*, pp 32-45.
- ⁴⁶ *Ibid*, pp 47-62.

This page intentionally left blank

MDCH – Task Force on Nursing Practice – Position Paper 3

Clarify Delegation of Nursing Functions

Recommendation: To improve access to safe, high quality healthcare for Michigan residents, State Government must make changes to the Michigan Public Health Code (MPHC), the Michigan Board of Nursing Administrative Rules, and other state statutes and regulations to ensure a clear definition of nursing delegation. The nursing delegation conflicts among sections of the MPHC and among the MPHC and other State statutes must be removed.

Nursing delegation - The act of transferring to a competent individual the responsibility to perform a selected nursing function in a selected situation within a directed scope of practice - the process for doing the work while retaining professional accountability for the outcome of care.^{1 2}

Summary of Issue

The Michigan Public Health Code (MPHC) defines delegation of healthcare tasks/activities/functions (hereafter termed functions) generically for all health professions.³ There are unique aspects of nursing delegation that require a clear definition specifically for nursing delegation. Healthcare workers performing nursing functions must be (but frequently are not) under the direction of a Registered Nurse (RN) who has the education and competencies required in nursing practice. Inconsistent delegation of nursing functions is unsafe and exists in all current practice settings. In some practice settings (schools, prisons, and long-term care facilities, for example), non-nursing personnel are delegating nursing functions to Licensed Practical Nurses (LPNs) and Nursing Assistive Personnel (NAPs).^{4 5} This situation results in an absence of: appropriate RN oversight, appropriate delegation, and appropriate supervision, with a consequent decrease in safe, high-quality healthcare. Today's evolving health care environment and continuum of delegation is broad and increasingly complex. The public is at risk in any practice setting in which unsafe nursing delegation occurs. Michigan statutes are inconsistent in their definitions and operationalization of nursing delegation, increasing the risk to the public's health and safety.

Summary of Solution

The definition of nursing delegation must be addressed specifically in Part 172, the nursing section of the MPHC. State Government must make changes to the MPHC, the Michigan Board of Nursing Administrative Rules, and other state statutes and regulations to include a clear definition of nursing delegation that is the same in all cases.⁶ Delegation of nursing care is a complex skill requiring sophisticated clinical judgment as well as final accountability for care of the client.⁷ All nurses need to have the knowledge, skills, and resources for initiation, acceptance, and appropriate performance of delegation within the practice setting. All aspects of nursing care of the patient must be under the supervision of an RN or an Advanced Practice Registered Nurse (APRN). Delegation, as defined above, permits RNs and APRNs to manage complex patient care needs, facilitate quality and safety, and promote cost containment.

Recommended Definition and Process for Nursing Delegation

Nursing Delegation is a complex skill that requires an understanding of the concepts of responsibility, authority, and accountability. Only RNs and APRNs may delegate nursing functions to LPNs or NAPs. Delegation belongs to the practice of RNs and APRNs.⁸ Elements that are essential in forming the foundation for delegation include professional nursing practice, task analysis, nursing rules and regulations, determination of the degree of supervision required for delegation, and feedback mechanisms for task completion and outcome. Clear articulation of the principles for delegation and clearly defined guidelines for delegation decisions are necessary.

Delegation principles include:

1. The nursing profession determines the scope of nursing practice
2. The Registered Nurse takes responsibility and accountability for the provision of nursing practice

3. The Registered Nurse directs care and determines the appropriate utilization of any assistant involved in providing direct patient care
4. The Registered Nurse is immediately available to communicate with the delegatee in person, by telephone, or by communications device⁹
5. The nursing profession defines and supervises the education, training and utilization for any assistant roles involved in providing direct patient care.¹⁰

Both the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) specify that an RN can give another individual direction to do something that individual otherwise would not be allowed to do, with the RN retaining accountability for that delegation. Prior to any delegation of selected nursing functions, RNs and APRNs must conscientiously use their critical thinking skills in evaluation of the type of care required, circumstances of care, and competence of the caregivers to whom tasks will be delegated. The abilities to delegate, assign, and supervise are critical competencies for the 21st century nurse.¹¹

The *Rights of Delegation* include:

1. The right task – one that is delegable for a specific patient.
2. The right circumstances – the appropriate patient setting, available resources, and other relevant factors that are considered.
3. The right person – the right person is delegating the right task to the right person to be performed on the right person.
4. The right direction/communication – clear, concise description of the task, including its objective, limits, and expectations.
5. The right supervision – Appropriate monitoring, evaluation, intervention as needed, and feedback.¹²

The definition and process above ensures that best practices in nursing delegation are performed in all practice environments and settings.

Sub-Recommendations and Reasons

Recommendation 3a - Defining Nursing Delegation

The recommended definition and process for nursing delegation (see above definition and process) must be completely and explicitly stated in: Part 172 of the MPHC, Nursing (333.172); Part 217 of the MPHC, Skilled Nursing Homes; and in the Nursing Homes and Care Facilities section of the Michigan Administrative Code (Rules); as well as the Michigan Education Code. The process of nursing delegation must include adherence to professional standards and the principles of delegation.^{13 14}

Reasons for Recommendation 3a - Inconsistency in nursing delegation must be removed to protect the safety and quality of healthcare provided to patients, including children in school, and persons in long term care facilities. A clear, explicit definition that includes delegation processes and skills, must be transferable to all practice environments, including environments based on current and emerging technologies. When a nursing function is delegated, the RN is responsible to assure that it is performed in accordance with established standards of practice, policies, and procedures. The quality and safety of patient care are facilitated by providing guidelines for a decision-making process for RNs and assistive personnel in all health care settings. Delegation permits RNs to manage complex patient care needs, facilitate quality and safety, and promote cost containment.

Recommendation 3b - Delegating Nursing Functions to LPNs and NAPs

The profession of nursing must determine how to continue providing safe, effective nursing care to patients through appropriate delegation of nursing functions to LPNs and NAPs.¹⁵ All decisions related to delegation and assignment of nursing functions must be based on protecting the health, safety and welfare of the public.¹⁶

Reasons for Recommendation 3b - The nation and Michigan have an increasingly aged population with multiple chronic diseases. Due to economic pressures, hospital stays are shorter and patient acuity is higher; those same economic pressures ensure that an increasing percentage of nursing functions are delegated to LPNs and NAPs. In addition, as hospital patients are discharged earlier and people with multiple chronic conditions are homebound, the demand for home health services is increasing. All of these factors require greater numbers of nurses and NAPs.¹⁷ Nursing functions are assigned or delegated to assistive personnel by RNs based on: the needs and condition of the patient; the potential for harm to the patient; the complexity of the task; the patient's condition; predictability of outcomes; competence of the staff to whom the task is delegated; and other patient needs.¹⁸

In Michigan, Licensed Practical Nursing is a subfield of nursing and LPNs (as well as NAPs) function under the supervision of RNs. The RN can delegate the performance of a nursing function to the LPN or NAP and supervise the performance of that function, but the ultimate accountability for the outcome of care is retained by the RN. Competent RN supervisors and appropriately supervised assistive personnel are needed in all practice settings to provide quality health care. The profession of nursing must be directly engaged in the process of ensuring this outcome. [See Position Papers 4 and 5 for more detailed discussions of LPN and NAP roles, practice, and regulation.]

Recommendation 3c-1 - Nursing Delegation Curriculum

The Michigan Nursing Education Council must develop, test, and support implementation of a uniform curriculum module and Continuing Education module for nursing delegation. Nursing students should be provided both didactic content and application of that content, with emphasis on patient safety as complexity increases with the number of caregivers.^{19 20}

Recommendation 3c-2 - Continuing Education in Nursing Delegation

The Michigan Board of Nursing must require continuing education (CE) in delegation, teaching consistent principles for delegation, clearly stated guidelines, and nursing delegation roles. Competencies needed for effective delegation - professionalism, critical thinking, leadership, authority, communication, and nursing expertise²¹ - must be included in Continuing Education for delegation.

Reasons for Recommendation 3c - Effective delegation requires that an RN knows the principles and guidelines and has a body of practice experience and the authority to implement the delegation.²² A newly licensed RN is a novice who is still acquiring foundational knowledge and skills.²³ Implementation of a uniform nursing delegation curriculum in nursing education would provide: a) a foundation on which newly licensed nurses may build through experience and continuing education; and b) greater clarity and consistency for nursing employers and administrators in healthcare facilities, institutions and organizations. Delegation is a skill that must both be taught and practiced for RNs to be proficient in using it in the delivery of nursing care.²⁴ Delegation is a process that involves professional development and application of critical thinking, improving with required continuing education and experience.²⁵ At present, many RNs lack the knowledge, the skill, and the confidence to delegate effectively and safely; this is due to many factors, such as not having had educational opportunities to learn how to work with others effectively, not knowing the skill level and abilities of NAPs, or not having the time to delegate properly.²⁶ Delegation skills must be developed on a foundation of education, and improved through continuing education and experience.

Who Will Benefit from the Recommended Solution?

This solution will benefit the people of Michigan, whose access to high quality, safe healthcare in all settings will be positively impacted as delegation-prepared RNs delegate nursing functions to appropriately prepared LPNs and NAPs.²⁷ This will permit the provision of high-quality healthcare while improving healthcare cost containment.

This solution will benefit the individuals, companies, and government agencies purchasing healthcare insurance and services for recipients of healthcare in Michigan, since RNs will be educated and prepared to appropriately delegate nursing functions to LPNs and NAPs. This staffing combination will be capable of providing effective, efficient healthcare services, while containing healthcare costs.

This solution will benefit healthcare regulators, administrators, RNs, LPNs, and NAPs, since there will be greater consistency in RN preparation and in expectations for all the parties engaged in delegation and performance of delegated nursing functions. Improved knowledge of delegation decision-making criteria, supervision, and evaluation will improve the reliability of nursing delegation as a method for providing high-quality healthcare services with good outcomes for patients. This will become more important as the federal government adopts pay-for-performance approaches for healthcare providers.

This solution will benefit children whose school has a school nurse,²⁸ since the risk to children requiring health care services in a school with a school nurse will be reduced. The school nurse will have the authority to decide which school personnel are adequately trained and competent to receive responsibility for delegated nursing functions needed by school children with various health conditions.²⁹ The school nurse also will provide appropriate training, supervision, and evaluation for the school personnel to whom the nurse has delegated nursing functions. Children needing health care services in school will remain at risk if their school has no school nurse.³⁰

This solution will benefit individuals living in Long Term Care (LTC) facilities and their families, since the risk to LTC patients will be reduced when LPNs are no longer serving as “charge nurses.”³¹ Since LPNs are not licensed to delegate nursing functions to anyone else, RNs will serve as charge nurses, delegating nursing functions to LPNs and NAPs in accordance with the guidelines of delegation. RNs have the education and competencies required to select delegates on the basis of their education and competence, supervise performance of delegated nursing functions, and evaluate delegatee performance.

Background: Michigan’s strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP was composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met from December 2010 through April 2012, gathered information, consulted with state and national experts in nursing practice and policy, and considered issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Clarifying Delegation of Nursing Functions was determined by the TFNP to be high priority.

Appendix A – Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Assignment - The distribution of work for which each staff member is responsible during a given work period. “Assign” is used to describe those situations when a nurse directs an individual to do something the individual is already authorized to do.³² Once a function has been delegated to an individual, the function may be assigned to that individual for a given work period. [See definition of nursing delegation]

Communication between delegator and delegatee - Must be a two-way process that permits both delegator and delegatee to ask questions and seek clarification. The exchange between the Registered Nurse (RN) delegator and the delegatee to whom responsibility for appropriate performance of the nursing function) is given requires constant evaluation, feedback, and modification to achieve the results needed to meet patient care goals.³³ [See definition of nursing delegation]

Licensed Practical Nurse (LPN) - *LPN practice is a subfield of nursing. Therefore, practice as a LPN means practice of nursing under the delegation and supervision of a Registered Nurse (RN).³⁴ LPNs are responsible for their actions in the performance of delegated nursing functions, tasks and activities, while the supervising RN is accountable for the overall care and safety of the patient/client and the outcomes of nursing care.*

Nurse - *When used without modification or amplification, means only a registered nurse.³⁵*

Nurse Aide - *Any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.*

Nursing Assistive Personnel (NAPs) - *Individuals trained to function in an assistive role to the licensed registered nurse in providing patient care activities as delegated by the Registered Nurses (RNs), regardless of the title of the individual to whom nursing functions are delegated. RNs may delegate selected nursing functions to NAPs who have appropriate education and competencies.³⁶ The term NAP includes, but is not limited to, Certified Nursing Assistant, Nurse’s Aide,³⁷ Patient Care Technician, medication aides, orderlies, attendants, or technicians.³⁸ NAPs are responsible for their actions in the performance of delegated nursing tasks and activities, while the supervising RN is accountable for the safety of the patient/client and the outcomes of nursing care.*

Nursing delegation - *The act of transferring to a competent individual the responsibility to perform a selected nursing function in a selected situation within an authorized scope of practice, the process for doing the work while retaining professional accountability for the outcome of care.^{39 40} [See full definition and process for nursing delegation in Recommendation #3]*

Nursing process - *A professional, systematic approach to ensuring complete care. The process consists of various steps including assessing, diagnosing, planning, implementing and evaluating the care provided.⁴¹*

Practice of Nursing - *The systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition.^{42 43} Nursing is a profession that is evidence-based, and requires an understanding of the human condition and applies the current science of professional caring⁴⁴ to health goals mutually established with patients goals.⁴⁵*

Supervision - *The active process of directing, guiding and influencing the outcome of an individual’s performance of a task. Supervision is generally categorized as on-site (the Registered Nurse (RN) being physically present or immediately available while the task is being performed) or off-site (the RN has the ability to provide direction through various means of written and verbal communication). Individuals engaging in supervision of patient care should not be construed to be managerial supervisors on behalf of the employer.⁴⁶*

End Notes

- ¹ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse
- ² American Nurses Association and National Council of State Boards of Nursing. (2006). *Joint Statement on Delegation*.
- ³ Michigan Nurses Association (1996). *Delegation in Nursing Practice*.
- ⁴ School nurses report to school principals or superintendents, who specify delegation of nursing functions, just as mental health nurses in Corrections facilities report to Corrections officers or managers, who specify delegation. These arrangements put patients at risk and endanger the licenses of the nurses involved, but lower costs for the facilities.
- ⁵ American Nurses Association (2007). Registered Nurses Utilization of Nursing Assistive Personnel in All Settings. *The American Nurses Association (ANA) reaffirms its belief that the utilization of nursing assistive personnel (NAP) in the provision of specific aspects of direct and indirect patient care, as the result of delegation and direction by a registered nurse (RN) in accordance with state nurse practice acts, is an appropriate, safe, and resource-efficient method of providing nursing care.* Nursing assistive personnel often have been referred to as unlicensed assistive personnel. However, in various states these individuals are now licensed or in some other way formally and legally recognized. Therefore, the term “unlicensed” is no longer accurate.
- ⁶ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Delegation of nursing functions resides solely with the RN. However, nursing delegation is not well defined and often is misunderstood. Many inconsistencies pertaining to nursing delegation exist in the MPHC, Education Code and MIOSHA Statutes, from the provision of health care to children in schools, the license of the nurse authorizing delegation, to delegation in nursing education. These inconsistencies must be changed for the safety and quality of healthcare provided to patients.
- ⁷ National Association of School Nurses. (2010) *Position Statement on Delegation*.
- ⁸ Weydt, Alice (2010). Developing Delegation Skills. *Nursing World*.
- ⁹ This delegation principle was added to the original list by the members of the MDCH-Task Force on Nursing Practice to support the current and future use of communication devices in nursing delegation and supervision.
- ¹⁰ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse
- ¹¹ American Nurses Association and National Council of State Boards of Nursing (2006). *Joint Statement on Delegation*.
- ¹² National Council of State Boards of Nursing. (1995). *Concepts and decision-making process*. Retrieved July 29, 2009, from www.ncsbn.org/323.htm
- ¹³ *Ibid*.
- ¹⁴ The TFNP and the Michigan Nursing Practice Council (successor group) must monitor the work of the Michigan Task Force on School Nurses and the implementation of that task force’s recommendations.
- ¹⁵ Kleinman, C & Saccomano, S. (2006). Registered Nurses and Unlicensed Assistive Personnel: An Uneasy Alliance. *Journal of Continuing Education in Nursing*. Vol. 37, No 4; pp 162-170.
- ¹⁶ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse
- ¹⁷ Kleinman, C, *op cit*.
- ¹⁸ American Nurses Association and National Council of State Boards of Nursing. (2006). *Joint Statement on Delegation*.
- ¹⁹ Ebright, P., (2010) The Complex Work of RNs: Implications for Healthy Work Environments. *Online Journal of Issues in Nursing* Vol. 15, No. 1, Manuscript 4.
- ²⁰ Ebright, P., L. Urden, E. Patterson, and B. Chalko (2004). Themes Surrounding Novice Nurse Near-Miss and Adverse-Event Situations. *Journal of Nursing Administration*. Vol. 34, No. 11.
- ²¹ Delegation, when properly taught and performed, includes the nursing competencies of professionalism, critical thinking, leadership, authority, communication, and nursing expertise. MDCH-Task Force on Nursing Practice.
- ²² American Nurses Association and National Council of State Boards of Nursing, *op cit*.
- ²³ *Ibid*.
- ²⁴ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse
- ²⁵ *Ibid*.
- ²⁶ American Nurses Association and National Council of State Boards of Nursing, *op cit*.
- ²⁷ Abstract of a Nursing Practice Issue Statement Received by the TFNP: There is variation in the preparation, regulation and use of Unlicensed Assistive Personnel (UAP) and Nursing Assistive Personnel (NAPs) presenting challenges to both nurses

and assistants. In addition, the use of individuals who are not educated nor have the competencies or skill sets to perform health care functions presents substantial risk to safe patient care.

²⁸ Michigan ranks last (51st) of 50 states plus the District of Columbia in the ratio of school nurses to K-12 students. In our state, the ratio is one school nurse to every 4,411 students. *National Association of School Nurses*, 2010.

²⁹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Nursing delegation in schools is complex and difficult. Students with diabetes often have complex orders for their care at school. If the student requires insulin injections, school nurses (as directed by the school principal or superintendent) train unlicensed school staff to administer the insulin to the student. However, those trained often do not feel comfortable administering insulin, which requires a multi-step process: a) monitoring blood glucose; b) using the blood glucose test results to decide how much insulin should be given; c) injecting the appropriate amount of insulin; and d) observing the student's response to the insulin. Student safety can be compromised if the unlicensed school staff-persons are not supervised appropriately. The school nurse has the responsibility to decide which nursing functions may safely be delegated to specific unlicensed staff; school principals or superintendents serving *in loco parentis* (in place of parents) for students do not have the education or clinical experience needed to make these decisions.

³⁰ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Clear regulations and policies that a) provide for the safety of schoolchildren with health needs, and b) meet the nursing practice requirement for school nurses are needed in Michigan. For over 25 years, two Michigan Attorney General Opinions (6476 and 5679 from the 1980's) have allowed schools to administer medication to students with or without a physician order and with or without a nurse on staff. There is confusion surrounding the AG's opinions, how they affect school nurse practice, and whether they are outdated or still valid, considering current health care practice. Untrained school staff who administer medications to students without physician orders or RN supervision or training put students at risk and have the potential to provoke negative medication side effects and interactions.

³¹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: The MPHIC includes conflicting sections on how delegation is performed and by whom in specific nursing care settings. The Nursing section of the MPHIC states that LPNs perform nursing functions under the delegation and supervision of an RN. The Nursing Home/Long Term Care section (Part 217) of the MPHIC states that a "licensed nurse" (which could be either an RN or an LPN) must serve as "charge nurse" assigning nursing care functions to assistive personnel (aides) on the staff of the facility. This means that LPNs who work as charge nurses in Long Term Care (LTC) facilities are in violation of their license, and that patients in LTC facilities are at risk for receiving unsafe care.

³² American Nurses Association and National Council of State Boards of Nursing. (2006). Joint Statement on Delegation.

³³ American Nurses Association. (2005). *ANA Principles for Delegation*.

³⁴ National Council of State Boards of Nursing. (2009). Model Nursing Practice Act and Model Nursing Administrative Rules.

³⁵ State of Wisconsin laws: Chapter 441. Subchapter I, Regulation of Nursing. 441.001 Definitions.

³⁶ National Council of State Boards of Nursing. (2009). Model Nursing Practice Act and Model Nursing Administrative Rules.

³⁷ In Michigan, Certified Nurse's Aides (CNAs) working in Long Term Care (Nursing Homes) have been regulated by the Bureau of Health Professions since 2000. CNAs are regulated under a federal statute, which requires that each state maintain a registry of CNAs, verify that they have 75 hours of training, and run a criminal background check on applicants; there are limited penalties for infractions of the federal statute. Many states require 120 hours of appropriate training for CNAs; Michigan should amend the MPHIC to include CNAs and NAPs.

³⁸ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse

³⁹ *Ibid.*

⁴⁰ American Nurses Association and National Council of State Boards of Nursing. (2006). Joint Statement on Delegation.

⁴¹ American Nurses Association, *op cit.*

⁴² *Occupational Regulation Sections of the Michigan Public Health Code*; MDCH Authority: P.A. 368 of 1978 as amended

⁴³ American Nurses Association. (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition.

⁴⁴ Watson defines nursing "as a human science of persons and human health – illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions" (1988b, p. 54). In addition, she also views nursing as both a science and an art. *Watson, J. (1988b). Nursing: Human science and human care. A theory of nursing* (2nd printing). New York: National League for Nursing. (Original work published in 1985.)

⁴⁵ Watson, Jean. (2008). *Nursing: The Philosophy and Science of Caring*. University Press of Colorado.

⁴⁶ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse

This page intentionally left blank

MDCH – Task Force on Nursing Practice – Position Paper 4

Delineate the Practice and Role of Licensed Practical Nurses

Recommendation: To improve access to safe, quality healthcare for Michigan residents, State Government should strengthen the Michigan Public Health Code and the Administrative Rules of the Michigan Board of Nursing (MBON) with respect to the Practice and Role of Licensed Practical Nurses (LPNs). Nursing titles, definitions, roles, delegation, and practice must be regulated only under Michigan Public Health Code (MPHC) Part 172, Nursing. No other State statute or regulation shall regulate these aspects of the profession of Nursing. Implementation of these changes must include a four-year transition and notification period to permit adjustments on the part of affected individuals and organizations.

Summary of Issue

The Michigan Public Health Code (MPHC) defines Licensed Practical Nurse (LPN) practice as a subfield of nursing.¹ As a subfield of Nursing, the role and practice of the LPN requires that nursing tasks, activities, or functions (hereafter termed “functions”) be delegated and supervised by a Registered Nurse (RN). At present, conflicts between MPHC Part 172 Nursing (333.172) and MPHC Rules for Nursing Homes (325.207) and Nursing Care Facilities Part 7 cause practice dilemmas for LPNs and the RNs who delegate and supervise LPN practice.

- Registered Nurses ask: What nursing functions can an LPN perform? What are the core competencies of an LPN? The MPHC states: “Practice of nursing as a “licensed practical nurse” or “LPN” means the practice of nursing based on less comprehensive knowledge and skill than that required of a registered nurse and performed under the supervision of a Registered Nurse, Physician, or Dentist.”²
- The nursing practice of an LPN is a directed scope of practice, under the delegation and supervision of the RN³ When an LPN is practicing as a charge nurse in a Nursing Home, the language of MPHC Rules for Nursing Homes and Nursing Care Facilities Part 7 does not specify the role of the RN or the LPN; rather, the MPHC describes the charge nurse as a “licensed nurse” - an ambiguous term which could mean either an RN or an LPN. This ambiguity puts patients at risk and nurses at risk of violating the provisions of the MPHC Nursing section, under which both RNs and LPNs are licensed.
- LPNs may perform nursing functions that are delegated and supervised by an RN; LPNs may not delegate those nursing functions to others. Charge nurses in Nursing Homes/Long Term Care often are LPNs responsible for the immediate direction and supervision of nursing care provided to patients.⁴ This may fulfill the provisions of MPHC Rules for Nursing Homes and Nursing Care Facilities Part 7, but it causes the LPN to be out of compliance with MPHC Part 172, Nursing.
- Healthcare workers (including LPNs) who are performing nursing functions must be under the direction of a RN who has the education and competencies required in nursing practice. Unsafe variations in delegation and supervision of nursing functions exist in all current practice settings. When there is an absence of appropriate (RN) nursing oversight, there is increased risk of errors, and absence of safe, high-quality healthcare. The public is at risk in any practice setting in which nursing activities are not appropriately delegated and supervised by an RN.
- LPN practice, as a subfield of RN practice, requires clear definitions with respect to the LPN directed scope of practice and role. The Administrative Rules of the MBON need more explicit guidelines for LPN scope of practice in all practice settings.

Summary of Solution

To improve access to safe, high quality healthcare for Michigan Residents, nursing titles, definitions, roles, delegation, and practice must be regulated only under MPHC Part 172 Nursing. The MBON Administrative Rules must be strengthened with respect to the practice and role of LPNs. Other State statutes and regulations shall not regulate nurses and nursing, and shall defer to MPHC Part 172 (333.172). LPNs have a directed scope of practice; when LPNs are performing nursing functions, they must do so under the delegation and supervision of a RN. LPNs must be regulated only under the Nursing

section of the MPHC in all nursing practice venues.⁵ Since the RN is held accountable for the safety of the patient and outcomes of nursing care, the MPHC Nursing provisions (333.172) must apply to all venues of nursing practice, including long term care, schools, hospitals, other institutions, and home health. Implementation of these changes must include a four-year transition and notification period to permit adjustments on the part of affected individuals and organizations.

Sub-Recommendations and Reasons

Recommendation 4a - Licensed Practical Nurse (LPN) “Directed Scope of Practice”

To improve access to safe, high quality healthcare for Michigan residents, it is recommended that the National Council of State Boards of Nursing (NCSBN) definition and practice of a Licensed Practical Nurse (LPN) be added to Michigan Board of Nursing (MBON) Administrative Rules to strengthen interpretation of the LPN scope of practice and to inform employers, patients and licensees. The NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules⁶ states in section 3 that “practice as an LPN means a *directed scope of nursing practice*, with or without compensation or personal profit, under the supervision of a Registered Nurse (RN), Advanced Practice Registered Nurse (APRN), licensed Physician or other health care provider authorized by the state, is guided by nursing standards established and recognized by the Board of Nursing (BON) and includes, but is not limited to:

- a. Collecting data and conducting focused nursing assessments of the health status of individuals. A focused assessment is an appraisal of an individual’s status and situation at hand, contributing to comprehensive assessment by the RN, supporting ongoing data collection and deciding who needs to be informed of the information and when to inform. [The comprehensive assessment is completed by the RN.]⁷
- b. Planning nursing care episodes for individuals with *stable* conditions.
- c. Participating in the development and modification of the comprehensive plan of care for all types of clients.
- d. Implementing appropriate aspects of the strategy of care within a client-centered health care plan.
- e. Communicating and collaborating with other health care professionals.
- f. Providing input into the development of policies and procedures.
- g. Other acts that require education and training as prescribed by the BON, commensurate with the LPN’s experience, continuing education and demonstrated competencies.

Additions to the LPN scope of practice are based on the various elements that make up this scope evidenced by the most recent job analysis. **This remains a directed scope of practice.”⁸**

Reasons for Recommendation 4a - Adding this NCSBN statement on LPN practice to the MBON Administrative Rules will strengthen the MBON interpretation of LPN practice and role, and provide guidance to the MBON, RNs, LPNs, their employers, and the public. LPNs have a directed scope of practice⁹ that reflects the required education, license and experience of the LPN.¹⁰ Utilization of LPN competencies under the delegation and supervision of an RN will improve access to safe, quality healthcare and realize the cost reduction that delegated care may provide. RNs carry a major responsibility in delegation and supervision of care. Healthcare is changing rapidly, and the acuity of patients is increasing. To keep patients safe, a best-practice decision-tree algorithm for delegation of nursing functions should be utilized in all care settings.¹¹

Recommendation 4b - Eliminate the Conflicts between MPHC Nursing Part 172 and MPHC Rules for Nursing Homes and Nursing Care Facilities Part 7

To improve access to safe, high quality health care for the residents of Michigan, anyone performing nursing functions and care must be regulated only under MPHC Part 172 Nursing (333.172). Nursing must regulate the practice of nurses in all care settings. Therefore, the conflicts between the definitions under MPHC Part 172 Nursing and the definitions under MPHC Rules for Nursing Homes and Nursing Care Facilities Part 7 Nursing Services must be eliminated through deferral to MPHC Part 172 (333.172).

RNs are the only nurses who delegate and supervise clinical nursing care and therefore are the only nurses who may serve as Long Term Care charge nurses or serve in any clinical supervisory role. State implementation of these changes must include a four-year transition and notification period to permit adjustments on the part of affected individuals and organizations.¹²

Reasons for Recommendation 4b - Under MPHC Part 172 Nursing Section, LPN practice is defined as a subfield of the practice of nursing; therefore, LPNs practice under the delegation and supervision of an RN. LPNs cannot delegate nursing functions to anyone else. However, under MPHC (325.20702) Rules for Nursing Homes and Nursing Care Facilities Part 7 a, “licensed nurse shall be the charge nurse on each shift or tour of duty and shall be responsible for the immediate direction and supervision of nursing care provided to patients in Long Term Care facilities.” Since both RNs and LPNs are licensed nurses, this ambiguous rule permits LPNs to serve as charge nurses. And indeed, this is exactly what occurs: LPN’s in most LTC facilities are performing charge-nurse duties. This does not protect the health and safety of LTC residents.^{13 14} Over the past ten years, LTC facilities increasingly have served patients requiring acute care^{15 16} due to earlier hospital discharges and the prevalence of multiple chronic conditions in an aging population.¹⁷ The RN is qualified to manage the care coordination needs of this population, delegate nursing functions, and supervise the outcomes of care.¹⁸

Who Will Benefit from the Recommended Solution?

This solution will benefit the people of Michigan, whose access to safe, high-quality healthcare will be positively impacted when LPN practice is consistently regulated under the Nursing section of the MPHC (333.172), in all practice venues. Patient safety will increase and confusion among healthcare professionals about LPN practice will decrease when there are clear definitions with respect to LPN practice as a sub-field of nursing under the delegation and supervision of an RN. LPNs may have a directed practice to the full extent of their required education, competencies, and license, appropriately expanding the healthcare workforce.

This solution will benefit LPNs and protect them by offering greater clarity. It will inform employers, patients, and currently practicing LPNs regarding the directed scope of practice and role of LPNs under the supervision of the RN.

This solution will benefit long term care residents because patient safety will increase and confusion among healthcare professionals will decrease when there is clarity regarding LPN directed scope of practice under the supervision of the RN.

Background: Michigan’s strategic plan for dealing with the nursing shortage, The Nursing Agenda for Michigan, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP is composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met for the first time in December 2010 and continues through April 2012 to gather information, consult with state and national experts in nursing practice and policy, and consider issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Delineating the Practice and Role of Licensed Practical Nurses in Michigan has been determined by the TFNP to be of high priority.

Appendix A – Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Competence - The application of knowledge and the interpersonal decision-making and psychomotor skills expected for the practice role within the context of public health, safety and welfare.¹⁹

Focused nursing assessment by an LPN - An appraisal of an individual's health status and the situation at hand; contributing to comprehensive assessment by the Registered Nurse, supporting ongoing data collection and deciding who needs to be informed of the information and when to inform.

Licensed Practical Nurse (LPN) - *LPN practice is a subfield of nursing. Therefore, practice as a LPN means practice of nursing under the delegation and supervision of a Registered Nurse (RN).²⁰ LPNs are responsible for their actions in the performance of delegated nursing functions, tasks and activities, while the supervising RN is accountable for the overall care and safety of the patient/client and the outcomes of nursing care.*

Nurse - *when used without modification or amplification, means only a registered nurse.²¹*

Practice of nursing as a Licensed Practical Nurse (LPN) - *Is the practice of a sub-field of nursing performed under the supervision of a Registered Nurse (RN). "Practice as an LPN means a **directed scope of nursing practice**, with or without compensation or personal profit, under the supervision of an RN, Advanced Practice Registered Nurse (APRN), licensed physician or other health care provider authorized by the state, is guided by nursing standards established and recognized by the Board of Nursing (BON) and includes, but is not limited to:*

- a. Collecting data and conducting focused nursing assessments of the health status of individuals. A focused assessment is an appraisal of an individual's status and situation at hand, contributing to comprehensive assessment by the RN, supporting ongoing data collection and deciding who needs to be informed of the information and when to inform. [The comprehensive assessment is completed by the RN.]²²*
- b. Planning nursing care episodes for individuals with stable conditions,*
- c. Participating in the development and modification of the comprehensive plan of care for all types of clients.*
- d. Implementing appropriate aspects of the strategy of care within a client-centered health care plan.*
- e. Communicating and collaborating with other health care professionals.*
- f. Providing input into the development of policies and procedures.*
- g. Other acts that require education and training as prescribed by the BON, commensurate with the LPN experience, continuing education and demonstrated competencies.*

*Additions to the LPN scope of practice are based on the various elements that make up this scope evidenced by the most recent job analysis. **This remains a directed scope of practice.**"²³*

End Notes

¹ *Occupational Regulation Sections* of the MDCH Authority: P.A.368 of 1978 as amended, Part 172. Nursing.333.17208

² *Occupational Regulation Sections* of the MDCH Authority: P.A.368 of 1978 as amended, Part 172. Nursing.333.17208

³ National Council of State Boards of Nursing. (2011). *Model Nursing Practice Act and Model Nursing Administrative Rules*

⁴ Michigan Public Health Code; Public Act 368 of 1978; Part 217 Nursing Homes; R 325.20702 Charge nurses; Rule 702.

⁵ The business of many sub-acute/rehabilitation long term care (LTC) facilities is rapidly shifting to medical-surgical acute recovery care, rehabilitation care (after hospital acute care discharge), and hospice end-of-life care. To successfully compete for these categories of business and successfully retain federal Medicare funding under pay-for-performance criteria, such long term care facilities are preferentially hiring Registered Nurses. Thus sub-acute/rehabilitation LTC facilities eventually may render moot the conflicts between MPHC sections dealing with a) the Nursing profession and b) Nursing Homes. However, skilled nursing care LTC facilities serving persons with dementia, disabilities, or developmental delay are funded primarily by Medicaid and will continue to have a strong interest in reducing workforce costs by placing RN responsibilities on LPNs and even on unlicensed assistive personnel. The economics of long term care are likely to continue to put at risk the health and safety of Michigan residents.

⁶ National Council of State Boards of Nursing, *op cit.*

⁷ This parenthetical statement was added by the TFNP to clarify patient assessment responsibilities.

⁸ National Council of State Boards of Nursing, *op cit.*

⁹ Practice as an LPN means a *directed scope of nursing practice*, with or without compensation or personal profit, under the supervision of an RN, Advanced Practice Registered Nurse (APRN), licensed physician or other health care provider authorized by the state, is guided by nursing standards established and recognized by the Board of Nursing.

¹⁰ *LPN Issue Statement*: Currently in Michigan the scope of practice of Licensed Practical Nurses (LPN) is not clearly defined in the Michigan Public Health Code (MPHC) and faculty of LPN programs are often teaching tasks outside of a LPNs scope of practice. Specifically, there is confusion surrounding a LPNs role in IV therapy. The MPHC states LPNs can monitor but not start IV's in Nursing Homes; adding medications is determined by facility policy. In order to decrease the amount of LPNs practicing outside their scope of practice, the MPHC should include a clear scope of practice definition. By clearly defining the scope of practice of LPNs in the MPHC, LPNs will be able to practice to the full extent of their education and training and sufficiently complement the RN role.

¹¹ See Delegation Decision Algorithm. Nebraska Board of Nursing. Also NCSBN decision-making algorithm.

¹² The Michigan Council of Nursing Education Administrators (MCNEA) includes the leadership of two-year Associate Degree in Nursing (ADN) programs in Michigan; graduates of these programs may take the national licensure examination required to become a Registered Nurse. MCNEA should be engaged in the planning for implementation of Recommendation 4b, since LPNs who wish to advance to RN licensure will be likely to apply to Michigan ADN programs.

¹³ The current LTC practice of having a single RN nursing supervisor delegate nursing tasks and activities to LPNs, who in turn delegate nursing tasks to Certified Nursing Aides (unlicensed) is not legal. Under the MPHC: LPNs may perform delegated nursing tasks/activities, but may not delegate those tasks and activities to others. Delegation includes supervision and evaluation; delegation and supervision of nursing tasks and activities is appropriate for RNs and APRNs, but not LPNs.

¹⁴ *LPN Issue Statement*: There is wide variation in the practice of LPNs in the state of Michigan due to a lack of a defined scope of practice. In order to ensure consistency in practice, LPNs should be required to complete Board of Nursing approved coursework such as IV Therapy administration. According to NCSBN research, the largest areas of disparity in LPN practice include care planning, assessment, IV therapy, and teaching. Education and competencies in these areas need to be better defined. Patient safety would increase and confusion among healthcare professionals on LPN practice would decrease.

¹⁵ Jennings, Bonnie. *Chapter 23: Patient Acuity*. U.S. Department of Health and Human Services, Agency for Healthcare: Patient Safety and Quality: An Evidence-Based Handbook for Nurses. http://www.ahrq.gov/qual/nursesdbk/docs/JenningsB_PA.pdf. "Patient acuity is a concept that is very important to patient safety. Presumably, as acuity arises, more nursing resources are needed to provide safe care."

¹⁶ U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2004). Hospital Nurse Staffing and Quality of Care. *Research in Action*. Issue 14. <http://www.ahrq.gov/research/nursestaffing/nursestaff.pdf>. "The EPC report included five studies funded by AHRQ that examined the relationship between adverse patient outcomes and hospital nurse staffing. All five studies found at least some association between lower nurse staffing levels and one or more types of adverse patient outcomes."

¹⁷ U.S. Department of Health & Human Services. (2010). *Multiple Chronic Conditions: A Strategic Framework Optimum Health and Quality of Life for Individuals with Multiple Chronic Condition*.

¹⁸ Mollica, R., J. Gillespie. (2003). Care Coordination for People with Chronic Conditions. *Partnership for Solutions*, Johns Hopkins University.

¹⁹ National Council of State Boards of Nursing, *op cit.*

²⁰ *Ibid.*

²¹ State of Wisconsin laws: Chapter 441. Subchapter I, Regulation of Nursing. 441.001 Definitions.

²² This parenthetical statement was added by the TFNP to clarify patient assessment responsibilities.

²³ National Council of State Boards of Nursing, *op cit.*

This page intentionally left blank.

MDCH – Task Force on Nursing Practice – Position Paper 5

Update Regulation of Nursing Assistive Personnel

Recommendation: To improve access to safe, quality healthcare for Michigan residents, the government of Michigan must make changes in the Michigan Public Health Code (MPHC), and other State statutes and regulations, so that unlicensed Nursing Assistive Personnel (NAPs) *performing nursing functions* must do so under the delegation and supervision of a Registered Nurse. NAP titling, education/training, core competencies, and performance must be improved, made consistent, and be regulated (but not licensed) only under the Nursing portion of the Michigan Public Health Code (MPHC) and the Michigan Board of Nursing (MBON) Administrative Rules.

Summary of Issue

The many categories of unlicensed Nursing Assistive Personnel (NAPs)¹ are inconsistently titled, educated, and regulated under a confusing patchwork of federal and state statutes and regulations. The unlicensed NAP categories of Certified Nurse Aide (CNA) and Hospice Aides (HA) are regulated under federal statute and corresponding sections of the MPHC when working in Nursing Homes/Long Term Care/Hospice.² Certified Home Health Aides (CHHAs) are regulated only by federal statute, not by MPHC. When NAPs are working in hospitals or ambulatory care settings they are not regulated except through the healthcare facility's accreditation process.^{3 4 5 6} Inconsistencies and deficiencies in NAP titling, education/training, and competencies, plus conflicts in the regulation of NAPs in multiple sections of the Michigan Public Health Code (MPHC), Michigan Education Code, and federal and state regulations, make the utilization of NAPs inefficient and may place patients at risk.

Registered Nurses (RNs) who delegate nursing functions to NAPs must supervise the performance of these nursing functions. Such delegation and supervision is intended to preserve the quality and safety of patient care while controlling costs. NAPs have a valued and important role in providing specific, limited and routine care across all care settings.⁷ The potential benefits of delegation may be lost without consistent NAP titling and regulation of NAP education/training and performance. Currently, there are many categories of NAPs and inconsistent education/training and regulation of NAPs. RNs need to know the education and competencies of NAPs to appropriately delegate nursing functions. RNs retain responsibility for the outcomes of any delegated nursing function, and do not want to risk a poor outcome for patients. The inconsistent titling, education, and regulation and variable competencies of NAPs may lead RNs to perform most nursing functions personally, delegating fewer tasks and overloading the RN. This regulatory variation may adversely affect the quality and safety of patient care across all practice settings.

Summary of Solution

Utilization of NAPs and delegation of nursing functions to NAPs must be guided by the sound nursing judgment of RNs and predicated on the delivery of safe patient care across all settings. To improve access to safe, quality health care for the residents of Michigan, all NAPs performing nursing functions must be defined and regulated only under the Nursing portion of the MPHC. This will remove inconsistencies and contradictions among the Nursing section, Long Term Care section, and other sections of the MPHC, as well as other State statutes and regulations. RNs may delegate nursing functions to NAPs and supervise the performance of the delegated functions. However, since the RN is held accountable for the safety of the patient/client and the outcomes of nursing care no matter what the setting, the appropriate locus of control for regulation of the titling, education/training, competencies, and performance of NAPs is the Michigan Board of Nursing (MBON); MBON regulation does not imply licensure of NAPs. The federal nursing home statute requires that NAPs employed in LTC facilities, receive a minimum of 75 hours of training. Federal statutes also require a minimum of 75 hours of training for NAPs in Home Care and Hospice Care. To improve the quality and safety of nursing care provided to LTC patients, Home Care patients, Hospice patients, and patients in other healthcare facilities,

the MBON must convene a Task Force to set appropriate core competencies, standards for NAP education/training, appropriately expanded hours, and appropriate testing. The education/training and competencies of NAPs must be improved. Core competencies for NAPs must be standardized in the basic curriculum, and required education/training hours increased; additional competencies must be achieved through additional hours, depending upon the NAPs area of practice. The MBON is the appropriate locus of control for regulation of NAP education/training and competencies.

Variation in NAP Titling and Regulation by Practice Setting

See Appendix C - Table of NAP Titling, Education & Supervision Inconsistencies

Long Term Care/Nursing Homes

The category of NAP working in Long Term Care/Nursing Homes is the CNA. For current regulation of CNAs, see the Long Term Care/Nursing Home section of the MPHC (333.21795),⁸ and Code of Federal Regulations (CFR) §483.75.⁹ For the past 10 years, registration and background checks for CNAs and oversight of their education are within the purview of the Bureau of Health Professions, Department of Licensing and Regulatory Affairs. The federal nursing home statute requires that CNAs employed in LTC facilities receive a minimum of 75 hours of training. To ensure the quality and safety of nursing care provided to LTC patients and patients in other healthcare facilities, the education and competencies of CNAs must be improved. Basic core competencies for CNAs must be standardized in the minimum 75-hour curriculum, with more complex competencies achieved through additional hours, depending upon the CNA area of practice.

Through state statutes, many states have increased NAP training hours to reflect the increasingly complex NAP practice environment. The acuity level of LTC patients has increased and will continue to increase as more patients are discharged from hospitals at early stages of recovery and as an aging population requires complex care due to multiple chronic conditions. RNs are responsible for patient safety and outcomes related to nursing functions delegated to NAPs, but the MBON has no connection to or control over the education and competencies of NAPs. This is neither effective nor logical; it separates responsibility from authority, and puts the public's health at risk. The MBON is the appropriate locus for the uniform titling and regulation of NAPs and oversight of NAP education/training and competency, since NAPs perform nursing functions which must be delegated and supervised by RNs.¹⁰

Hospitals and Clinics

The categories of NAP working in hospitals and clinics are too numerous to list. Many are trained as CNAs, but may have any title the facility chooses to give them. Since there is minimal regulation of NAPs in hospitals or clinics (other than facility licensure & accreditation requirements), each facility determines the titles under which NAPs are employed, and the activities performed by NAPs. The MBON is most suited for the titling and regulation of NAPs and oversight of NAP education/training, since NAPs perform nursing functions which must be delegated and supervised by RNs. The utilization of Emergency Medical Services personnel (EMS) in hospitals is discussed in Appendix B – EMT Case Statement I.

Community

CFR §484.36¹¹ specifies the role of the NAP in home health care. The NAP working in home health care is titled Home Health Aide (HHA) or Certified Home Health Aide. HHA services are regulated only by federal statute, not by MPHC.¹² HHA training regulations were initiated in 1987 and have not been updated. The 1987 regulations indicate that the HHA training program must address more than 12 subject areas through classroom and supervised practical training for a minimum of 75 hours with at least 16 hours devoted to supervised practical training and a minimum of 16 hours of classroom training. HHA training needs updating to meet current patient needs. The MBON is the appropriate locus for the uniform titling and regulation of NAPs and oversight of NAP education/training, since NAPs perform nursing functions which must be delegated and supervised by RNs.^{13 14 15}

Hospice Care

CFR §418.76 (1987) specifies the Hospice Aide (HA) role as the NAP in hospice care. A HA training program must meet the requirements outlined in §418.76 or from Chapter IV §483-151-154. HA services are regulated only by the federal statute, not by the MPHC.¹⁶ Specifics related to supervision and duties are outlined in these sections. The HAs' education/training program must address more than 12 subject areas through classroom and supervised practical training for a minimum of 75 hours with at least 16 hours devoted to supervised practical training and a minimum of 16 hours of classroom training. The hospice is responsible for additional training for skills not covered in the basic core competencies. Accreditation organizations may require additional training and/or supervision. The MBON is most suited for the titling and regulation of HAs and oversight of HA education/training, since HAs perform nursing functions which must be delegated and supervised by RNs in Hospice services.

Schools/Education

The role of NAPs in schools has expanded as the classroom integration of students with complex, specialized healthcare needs has increased. Nearly 20% of children and adolescents have a chronic health condition, and nearly half of those students could be considered disabled.¹⁷ The categories of NAPs working in School Health are too numerous to list, but may include secretaries, athletic coaches, classroom aides, and school-bus drivers. School nurses (RNs) are regulated under two separate Acts: The MPHC Public Act 368, Article 15, Part 172, Nursing section (333.172) and Michigan Compiled Laws (MCL) 340.623 of the Public Acts of 1955, Act 269, Education. Both Acts regulate the functions of School Nurses, but School Nurses are also licensed under the MPHC, Nursing section (333.172).¹⁸ Act 269, Education, certification rules are vague as to the delegation and supervision of nursing functions to unlicensed non-nursing personnel functioning as NAPs. School nurses must follow the principles of nursing delegation and supervision.¹⁹ Inappropriate and illegal delegation of health care tasks could result in an NAP practicing nursing without a license (a felony).^{20 21 22}

The range of medications administered to students in school is very broad, including Emergency Medications, Over-the-Counter Medications, Controlled Substances, Alternative Medications, and Research Medications.²³ The most common drugs administered in Michigan schools are:

- Albuterol and other types of asthma medications
- Diazepam-Diastat (anxiety and seizure medications)
- Epinephrine injections (for life threatening allergic reactions)
- Insulin and Glucagon (Diabetes medications)
- Midazolam/Versed (Emergency drug for treatment of seizures in children. This drug is not approved for NAPs to administer.)

Considering that medication administration to students is one of the most common health-related activities performed in school, and that the student's health status must be assessed **before** medication is given, delegation of medication administration to NAPs is a serious responsibility, determined on a case-by-case basis.^{24 25} There is serious risk to students when appropriate assessment and oversight of medication administration by an RN is not maintained. The MBON is most suited for the titling and regulation of school NAPs and oversight of NAP education /training and competencies, since NAPs perform school nursing functions which must be delegated and supervised by RNs.²⁶

Mental Health Institutions and Clinics

The categories of NAPs working in Mental Health Hospitals, Community Mental Health Clinics, Forensic Mental Health (Correctional Institutions) include: Residential Care Aides, Peer Support Specialists, Direct Care Aide, and Forensic Security Aide.²⁷ Mental health institutions have patient confidentiality provisions beyond those applicable to other health providers, and also have additional internal investigative units. NAPs employed in mental health thus have a work environment different from that of other NAPs. NAPs working in mental health facilities and organizations will require specific education/training and

competencies for this specialized area. This adds to the difficulty of regulating the titling, education/training and competencies of NAPs working in mental health settings; but it does not change the need for improved education/ training, and oversight of NAPs for the safety and well being of patients.

Sub-Recommendations and Reasons

Recommendation 5a - NAP Regulation

To improve access to safe, quality health care for the residents of Michigan, anyone performing nursing functions must be titled, educated/trained, and regulated only under MPHC 333.172 Nursing section, and a single set of nursing regulations, the Michigan Board of Nursing (MBON) Administrative Rules. This regulation does not imply licensure of nursing assistive personnel.²⁸

Reasons for Recommendation 5a - RNs required to delegate nursing functions to NAPs must have confidence that NAPs are appropriately educated/trained, titled, and regulated, and have the core competencies required to safely perform delegated nursing functions. Currently, RNs are not able to predict the education/training and core competencies of NAPs, and often are reluctant to delegate to NAPs. This reduces the usefulness of NAPs, and ultimately reduces the amount and quality of healthcare available; it also voids the cost reduction inherent in appropriate delegation of nursing functions to NAPs. Elimination of the confusion, conflicts, and inconsistencies in defining, educating/training, utilizing and delegating to NAPs is a major factor in improving access to care and the healthcare system of Michigan.

Recommendation 5b - NAP Titling, Education/Training, and Core Competencies

To improve access to safe, quality healthcare for the residents of Michigan, the State of Michigan and a Task Force of the Michigan Board of Nursing must identify consistent titling, expanded core competencies, and standards for improved education/training and testing for NAPs across all settings.²⁹ The NAP core competencies must guide the development of a core curriculum for NAP education/training, with increased hours, increased supervised clinical hours, and improved testing.^{30 31} Additional competencies must be acquired through additional hours of education/training.

Reasons for Recommendation 5b - The many categories of unlicensed NAPs are inconsistently titled, regulated under a confusing patchwork of federal and state statutes and regulations, and inconsistently educated/trained by 190 public and private training programs, using a curriculum last updated in the mid-1980s. At present, NAPs who have completed training are tested by an outside agency, using tests that need to be updated and standardized. Many other states have moved to increase NAP training hours to 120 hours, beyond the 75-hour federal (and Michigan) minimum. Thirty states and the District of Columbia have extended the number of training hours for nurse aides beyond the minimum 75 hours.³² There are 13 states and the District of Columbia that meet the standard suggested by the IOM of 120 or more training hours.³³ For home health aides, 15 states exceed the federal minimum and only 5 meet the standard suggested by the IOM of 120 or more training hours.³⁴ To improve the feasibility and consistency of performance of nursing functions delegated to NAPs by RNs, there must be consistent NAP titling and core competencies, plus improved and expanded education/training and testing for NAPs. To improve NAP predictability, the basic curriculum for NAP education/training must cover the agreed upon core competencies, be consistently delivered, and appropriately tested. Further competencies must be acquired through additional hours of education/training. This will enable greater utilization of NAPs and protect the safety and quality of care provided to an aging patient population with many chronic conditions.

Recommendation 5c - Evidence-based Research as Framework for NAP Training

The State of Michigan and the nursing profession must promote national nursing initiatives as the base for establishing criteria and guidelines for the clinical training of NAPs. Through the use of evidence-based research, a consistent curriculum and additional training modules can be developed to prepare NAPs to

provide “routine care in predictable patient care functions with emphasis on age-appropriate competencies as determined by the patient care setting.”³⁵

Reasons for Recommendation 5c - If NAPs are to perform delegated nursing functions in a wide range of settings from schools to hospice, they must have education/training beyond their core competencies. To ensure that such education/training is current and age appropriate, evidence-based research findings must be used as the basis for development of education/training modules preparing NAPs for service in schools, hospitals, home health, hospice and a variety of other practice settings. RNs must be engaged in the design, implementation, and evaluation of such education/training modules to ensure that NAPs are consistently and appropriately prepared to receive delegated nursing functions from RNs.

Who Will Benefit from the Recommended Solution?

The public will benefit when NAP titling, education, core competencies, and performance are consistent so that RNs who delegate nursing functions to NAPs have confidence that NAPs are appropriately educated/trained, titled, and regulated, and have the core competencies required to safely perform delegated nursing functions.

Healthcare providers will benefit from clear guidelines for NAP titling, education, core competencies and confidence that the NAPs have appropriate education/training and competencies. This will improve the willingness of RNs to delegate nursing functions to NAPs, and realize the potential cost savings from appropriate delegation to NAPs.

Residents of Long Term Care facilities will benefit when NAPs have improved core competencies and the appropriate education/training to safely perform delegated nursing functions in an environment of patients with higher acuity and multiple chronic conditions.³⁶

Patients in Hospitals and Clinics will benefit from clear guidelines for NAP titling, education/training, core competencies, and confidence that the NAPs have appropriate education/training and competencies to perform delegated nursing functions safely.

NAPs will benefit, since improved core competencies and consistent education/training will require that NAPs receive tests of their vision, hearing, literacy, and health literacy - with appropriate remedial steps taken. NAPs also will have improved employment security, since employers will be better able to discern cost-benefit in the utilization of NAPs.

Background: Michigan’s strategic plan for addressing the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP is composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met for the first time in December 2010 and continued through April 2012 to gather information, consult with state and national experts in nursing practice and policy, and consider issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Updating Regulation of Nursing Assistive Personnel in Michigan has been determined by the TFNP to be of high priority.

Appendix A - Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Communication between delegator and delegatee - Must be a two-way process that permits both delegator and delegatee to ask questions and seek clarification. The exchange between the Registered Nurse (RN) delegator and the delegatee to whom responsibility for appropriate performance of the nursing function) is given requires constant evaluation, feedback, and modification to achieve the results needed to meet patient care goals.³⁷ [See definition of nursing delegation]

Licensed person - An individual who is licensed or otherwise legally authorized to practice a professional service by a court, department, board, commission, or an agency of this state or another jurisdiction.

Nurse - *When used without modification or amplification, means only a registered nurse.*³⁸

Nurse Aide - *Any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.*

Nursing Assistive Personnel (NAPs) - *Individuals trained to function in an assistive role to the licensed registered nurse in providing patient care activities as delegated by the Registered Nurses (RNs), regardless of the title of the individual to whom nursing functions are delegated. RNs may delegate selected nursing functions to NAPs who have appropriate education and competencies.³⁹ The term NAP includes, but is not limited to, Certified Nursing Assistant, Nurse's Aide,⁴⁰ Patient Care Technician, medication aides, orderlies, attendants, or technicians.⁴¹ NAPs are responsible for their actions in the performance of delegated nursing tasks and activities, while the supervising RN is accountable for the safety of the patient/client and the outcomes of nursing care.*

Nursing delegation - *The act of transferring to a competent individual the responsibility to perform a selected nursing function in a selected situation within an authorized scope of practice, the process for doing the work while retaining professional accountability for the outcome of care.^{42 43} [See full definition and process for nursing delegation in Recommendation #3]*

Regulation - 1) A law, rule or order prescribed by authority, especially to regulate conduct. 2) The act of regulating or the state of being regulated.⁴⁴

Registry - A hierarchical data base that stores specified information. [Example: MCL: 483.156, Registry of Nurse Aides. This section spells out the specific requirements of the registry content for Nurse Aides.]

Appendix B – Case Statement

Case Statement I – Emergency Medical Technicians Serving as Nursing Assistive Personnel

To protect the health and safety of the people of Michigan, State Government must make changes to the Michigan Public Health Code (MPHC) to regulate all Nursing Assistive Personnel (NAPs) performing nursing functions in the manner proposed in TFNP Recommendation and Position Paper 5. The NAP role must be defined and regulated under the nursing section of the MPHC with specifications regarding licensed Emergency Medical Service personnel serving in hospitals as NAPs.^{45 46} EMS personnel employed by hospitals to perform nursing functions must receive delegated tasks from and be supervised by Registered Nurse (RN) hospital staff.

1. EMS Personnel Licensure

Emergency Medical Services (EMS) personnel are licensed by the State of Michigan at four different levels: Medical First Responder (MFR), Emergency Medical Technician (EMT-Basic), Emergency Medical Technician-Specialist (EMT-Specialist), and Paramedic.⁴⁷ Michigan EMT licensure covers only out-of-hospital care and does not cover in-hospital care.⁴⁸ EMS personnel are not independent practitioners; the MPHC requires medical oversight for out-of-hospital EMT care.

2. EMT Practice Settings

Based on licensure, Michigan EMS personnel provide medical care only in out-of-hospital settings and are not licensed to provide care in hospitals settings. An increasing number of EMS professionals are functioning in health care settings other than out-of-hospital care. Common settings include, but are not limited to; hospital or clinic-based emergency departments,⁴⁹ hospital units (including critical care), physician's offices, and urgent care facilities. When EMS personnel are employed by and practice in hospital settings they must be supervised by: a) physicians if the EMTs are performing medical tasks; or b) hospital-employed RNs if the EMTs are performing nursing tasks.

3. Tasks Delegated to EMTs

EMS education and competencies are specific to emergency medicine and provision of care in out-of-hospital settings.⁵⁰ EMS licensure and education does not include nursing education or nursing competencies. When EMTs are assigned to hospital RNs for supervision, the only tasks that may be delegated to the EMTs are nursing tasks. RNs may not supervise EMTs performing medical tasks. A physician may not delegate medical functions to an EMT, and then assign supervision of that EMT to an RN - in any healthcare setting. State regulations must be clear about the delegated scope of practice for licensed EMS personnel. The employers of EMS personnel working in nontraditional roles and settings must be aware of what care functions the Michigan EMS license permits or prohibits in that setting.

4. RN Delegation to EMTs

Patient safety is compromised when EMS personnel are placed in situations and roles for which they lack experiential and/or educational preparation. Clinical and administrative supervision, regulation, and quality assurance must ensure EMS personnel are not placed in situations where they exceed their delegated scope of practice. For example, EMS personnel are not credentialed to perform patient assessments to the same education and competency level as RNs; therefore all patient assessments must either be performed by RNs or supervised by RN hospital staff. For the protection of the public, regulation must assure that EMS personnel are functioning within their delegated scope of practice, level of education, certification, and credentials.⁵¹

5. Employer Responsibilities

The education, experience, and competency necessary to perform delegated nursing tasks must be considered when delegating nursing functions to EMS personnel. Michigan EMS personnel are

licensed to provide medical care only in out-of-hospital settings. Therefore, employers must provide training, ensure competencies, and clearly define and limit patient care activities of EMS personnel to that of the NAP role when functioning under RN supervision. The NAP role is a delegated nursing role that must be performed under the direct supervision of an RN. Therefore, EMS personnel performing delegated nursing functions in acute care settings must be supervised by an RN.

Definitions

Michigan Educational Requirements for Licensed Emergency Medical Services Personnel

Education requirements for each of the four (4) categories of Medical Services Personnel:

1. **Medical First Responder (MFR)** - Requires 15 Michigan credit hours
2. **Emergency Medical Technician (basic) (EMT)** - Requires 30 Michigan credit hours and 42 additional credits in any category of EMS.
3. **Emergency Medical Technician-Specialist (EMT-Specialist)** - Requires 36 Michigan credit hours and 36 additional credits in any category of EMS.
4. **Paramedic** - Requires 45 Michigan credit hours and 27 additional credits and Advanced Cardiac Life Support (ACLS).⁵²

The categories of approved continuing education activities for all four (4) categories of Emergency Medical Services Personnel shall include, but are not limited to, all of the following topics:

- (a) Preparatory
- (b) Airway management and ventilation
- (c) Patient assessment
- (d) Trauma
- (e) Medical
- (f) Special considerations
- (g) Operations

Paramedics are required to maintain ACLS Certification in addition to other education requirements.

EMT Scope of practice - Defined parameters of various duties or services that may be performed by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it represents the limits of services an individual may legally perform. *National EMS Scope of Practice Model.*⁵³

Table 1: Nursing Assistive Personnel (NAPs) Performing Nursing Tasks in Various Care Settings

Setting	Long Term Care	Home Health Care	Hospice	Hospitals	Ambulatory Care Non-Hospital	Mental Health Hospitals	Community Mental Health	Correctional Facilities	Forensic Center	Schools
				Children's Hospitals						
NAP Titles	Certified Nurse Aide (CNA)	Home Health Aide (HHA)	Hospice Aide (HA)	Nurse Aide, Patient Care Aide, Patient Care Tech	Medical Assistant (MA)	Residential Care Aide (RCA)	Peer Support Specialist, Direct Care Aide, Others	Correctional Officer (CO)	Forensic Security Aide (FSA)	Unlicensed Assistive Personnel (UAP)
				Child Care Workers						
Preparation	75 hours of training federally mandated, requires certification	75 hours of training federally mandated, requires certification	75 hours of training federally mandated	Variable: CNA training, or courses	Variable: Some programs up to 9 months	Variable**	Variable**	Variable**	Variable**	Variable**
				Variable: CNA training, or courses						
Continuing Education	12 hours annually	12 hours annually	12 hours annually	Variable	Variable	Variable	Variable	Variable	Variable	Variable
				Unknown						
Delegation	RN/LPN delegates nursing functions through Patient Care Plans	RN delegates nursing functions through Patient Care Plans	RN delegates nursing functions through Patient Care Plans	RN delegates nursing functions	Physician & other MAs delegate medical & nursing functions	RN delegates nursing functions	RN delegates nursing functions to CMH staff, who oversee administration of meds.	RN delegates nursing functions through Supervisor of COs	RN delegates nursing functions to FSAs.	RN/LPN or MAs delegate nursing functions on orders of school officials
				RN delegates nursing functions						
Supervision	On-site supervision for CNA provided by LPN Charge Nurse	RN supervisory visit required every 2 weeks	RN supervisory visit required every 2 weeks	RN supervises nursing functions	RN supervises nursing functions	RN supervises nursing functions	RN provides indirect supervision of nursing functions	Supervisor of COs reports problems to RN.	RN serves as Unit Supervisor for FSAs.	UAPs report problems to school officials or RN.
				RN supervises nursing functions						
Regulation	MPHC* §333.21795 Nursing Homes	CFR 42 §485.150 - 158	CFR 42 §418.76	Accrediting organizations for hospitals	None	Mental Health Code; Accreditation and CMS Certification	Mental Health Code; Accreditation and CMS Certification	Criminal Justice Code	Mental Health Code & Criminal Justice Code; CMS Certification	Education Code
		Accrediting organizations for HHC	MPHC §333.25	Accrediting organizations for hospitals						
			Accrediting organizations							

*Michigan Public Health Code **Variable ranges from “did not graduate HS” to “some college.”

End Notes

¹ Unlicensed Nursing Assistive Personnel (NAPs) include Certified Nursing Assistants (CNAs), Nurse Aides (NAs), Home Health Aides (HHAs), Medication Technicians, Personal Care Attendants, Unlicensed Assistive Personnel (UAPs) and similar titles.

² Long Term Care/Nursing Home section of the MPhC Act 368 of 1978, Section 333.21795 Education and Training for Unlicensed Nursing Personnel, criteria, competency examinations; rules (Federal Rules & Regulations for Certified Nurse Aides Code of Federal Regulations (CFR) 42 Part 483 Subpart B Section 483.75 and Subpart D Sections 483.151 – 483.158).

³ The Joint Commission Accreditation, Health Care, Certification (JCAHO) accredits Hospitals, Critical Access Hospitals, Home Care, Ambulatory Health Care, Behavioral Health Care, Long Term Care, and Laboratory Services.

⁴ American Nurses Association. (2007) *Registered Nurses Utilization of Nursing Assistive Personnel in all Settings*.

⁵ American Nurses Association. (2005) *Principles for Delegation*.

⁶ Center for American Nurses (2006) *Registered Nurse Utilization of Nursing Assistive Personnel*.

⁷ *Ibid.*

⁸ Act 368 of 1978, Section 333.21795 Education and Training for Unlicensed Nursing Personnel, criteria, competency examinations; rules.

⁹ Federal Rules & Regulations for Certified Nurse Aides Code of Federal Regulations (CFR) 42 Part 483 Subpart B Section 483.75 and Subpart D Sections 483.151-483.158). <http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol5/pdf/CFR-2010-title42-vol5-sec483-75.pdf>

¹⁰ The current LTC practice of having a single RN nursing supervisor delegate nursing functions to LPNs, who in turn delegate nursing functions to CNAs is not legal. Under the MPhC: LPNs may perform delegated nursing tasks/activities, but may not delegate those tasks and activities to others. Delegation includes supervision and evaluation; delegation and supervision of nursing tasks and activities is appropriate for RNs and APRNs, but not LPNs.

¹¹ Title 42: Public Health Part 484 - Home Health Services Subpart C Furnishing of Services. Section 484.36 Condition of participation: Home health aide services. (54 FR 33367, August 14, 1989 as amended at 56 FR 32974, July 18, 1991; 56 FR 51334, Oct. 11, 1991; 59 FR 65498, Dec. 20, 1994; 60 FR 39123, Aug. 1, 1995; 66 FR 32778, June 18, 2001.

¹² For Federal Condition of Participation regulations for Home Health Care and Home Health Aids please see <http://www.gpo.gov/fdsys/pkg/FR-1997-03-10/pdf/97-5316.pdf> or <https://www.federalregister.gov/regulations/0938-AG81/home-health>

¹³ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Staff in adult foster care homes should be no less educated than at least an LPN. LPNs still don't have the pathophysiology, care planning, judgment, or ability, but it would be way better than the non-nursing, uneducated, staff that currently are staffing the homes.

¹⁴ Abstract of a Nursing Practice Issue Statement Received by the TFNP: There are huge (mostly unreported) medication errors in all of the adult foster care homes that I visit.

¹⁵ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Because of the nursing shortage and because no one wants to pay for RN's, high school graduates (if that) are staffing specialized residential adult foster care homes. ... Basically, real nurses cannot possibly teach the non-educated persons providing the care how to be nurses, and this is costing the health and safety of the patients, costing the public health system and raising the overall cost of healthcare.

¹⁶ For Federal Condition of Participation regulations for Hospice and Hospice Aids please see: <http://www.gpo.gov/fdsys/pkg/FR-2005-05-27/pdf/05-9935.pdf>

¹⁷ National Association of School Nurses, Position Statement (2011) *Unlicensed Assistive Personnel – The Role of the School Nurse*.

¹⁸ Trossman, Susan. (2011). At the Heart of the Professional Practice. *The American Nurse*. <http://www.theamericannurse.org/?s=At+the+heart+of+professional+practice>

¹⁹ American Nurses Association and National Council of State Boards of Nursing. (2006). *Principles of Delegation*.

²⁰ *Ibid.*

²¹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Currently in Michigan school nurses are delegating tasks to unlicensed school staff, but do not have the authority to choose which procedures can be delegated and which cannot. Therefore, in many instances, school nurses train unlicensed school staff to administer treatment to students. In situations where a student has diabetes and requires insulin injections, school nurses train unlicensed school staff to administer the insulin, but often those trained do not feel comfortable administering the shot without the school nurse present. This produces an unsafe practice environment where student safety is in jeopardy. If school nurses were authorized to designate which tasks could be delegated to unlicensed staff then patient safety would increase. Other possible solutions would be to develop a Nurse Practice Act, establish a Director of Nursing Practice at the Michigan Board of Nursing (MBON), and establish a state school

nurse consultant in the Department of Education. These possible solutions would help clarify and define delegation of responsibility and help address confusing policy situations for school nurses.

²² Abstract of a Nursing Practice Issue Statement Received by the TFNP: Two Attorney General Opinions (6476 and 5679) have allowed schools to administer medication to students with or without a physician order and with or without a nurse on staff. There is confusion surrounding the AG's opinions and how they affect school nurse practice. Confusion such as: do the AG's opinions deal specifically and only with medication administration, or do the opinions cover other nursing related tasks, such as catheterizations and blood glucose monitoring. Also, do these opinions require a physician to regularly oversee and provide consultation to review the practice and records and further educate the school employee? Clarification of this issue would increase patient safety and quality of care because current practice is unsafe for children in schools.

²³ National Association of School Nurses. (2011) *Medication Administration in the School Setting*.

²⁴ *Ibid*.

²⁵ Abstract of a Nursing Practice Issue Statement Received by the TFNP: Currently in Michigan, it is legal for unlicensed school personnel to administer over-the-counter (OTC) medications with written parental request without a licensed prescriber's order. Although it is legal for unlicensed school personal to administer the OTC medication it is illegal for a RN to administer the same medication with written parental request; a licensed prescriber's order is needed for RN's to administer OTC medication. In order to minimize unnecessary restrictions on School Nurses, schools should follow the Michigan Department of Education's model policy requiring a licensed prescriber's order for all medications. Unnecessary restrictions will also be eliminated by expanding the role of the National Certified School Nurse to administer OTC medications without written parental request. This change will allow safe practice to be monitored in schools by licensed prescribers, increasing the quality and safety of care in schools.

²⁶ National Association of School Nurses, *op cit*.

²⁷ Communication from Dr. Cynthia Arthur-Gift, Emerita Director of Mental Health Services, MDCH.

²⁸ Abstract of a Nursing Practice Issue Statement Received by the TFNP: School nurses in Michigan employed by RESD are asked to provide School Based Medicaid by writing orders for personal care services for paraprofessional to perform on students. School nurses are asked to develop "Plans of Care," and an evaluation tool for the paraprofessional. Many schools nurses are unaware if this request is within their scope of practice as a school nurse, or if a physician is required to write the original order. Scope of practice for school nurses needs to be better defined in the Public Health Code in order to lessen the confusion of school nurses, educators and healthcare professionals. Once the scope of practice for school nurses is better defined, school nurses will understand the parameters of their scope of practice and not fear that their license is in jeopardy by providing training to paraprofessionals.

²⁹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: School Nurses in Michigan are unaware of available educational resources that will assist them in developing Plans of Care for students. Also, the responsibilities for School Nurses in regards to Medicaid based care and the responsibilities associated with delegating those responsibilities to school employees are unclear. Education resources should be made readily available, so school nurses do not need to continuously "reinvent the wheel." Making resources available will help share best practices in delegating tasks for school employees and improve the care performed.

³⁰ American Nurses Association. (2007). *Registered Nurses Utilization of Nursing Assistive Personnel in all Settings*.

³¹ Examples of states with expanded hours, improved core competencies, and appropriate curriculum and testing include: Maine (180hrs); Missouri (175hrs); California (150hrs); Delaware (150hrs); Oregon (150hrs); Alaska (140hrs); Arizona (120hrs); D.C. (120hrs); Florida (120hrs); Idaho (120hrs); Illinois (120hrs); Virginia (120hrs); West Virginia (120hrs); Wisconsin (120hrs).

³² Paraprofessional Healthcare Institute. (2011). *Quality Care Through Quality Jobs: Nurse Aide Training Requirements*. Retrieved from www.phinational.org.

³³ *Ibid*

³⁴ Paraprofessional Healthcare Institute. (2011). *Quality Care Through Quality Jobs: Home Health Aide Training Requirements*. Retrieved from www.phinational.org

³⁵ American Nurses Association. (2007). *Registered Nurses Utilization of Nursing Assistive Personnel in all Settings*.

³⁶ Erb, R., K. Tanner. (2011). Troubled Nursing Homes Aren't Closed. *Detroit Free Press*.
<http://www.freep.com/article/20111211/FEATURES08/111207034>

³⁷ American Nurses Association (2005). *ANA Principles for Delegation*.

³⁸ State of Wisconsin laws: Chapter 441. Subchapter I, Regulation of Nursing. 441.001 Definitions.

³⁹ National Council of State Boards of Nursing (2009). *Model Nursing Practice Act and Model Nursing Administrative Rules*.

⁴⁰ In Michigan, Certified Nurse's Aides (CNAs) working in Long Term Care (Nursing Homes) have been regulated by the Bureau of Health Professions since 2000. CNAs are regulated under a federal statute, which requires that each state maintain a registry of CNAs, verify that they have 75 hours of training, and run a criminal background check on applicants; there are limited penalties for infractions of the federal statute. Many states require 120 hours of appropriate training for CNAs; Michigan should amend the MPHC to include CNAs and NAPs.

⁴¹ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatIsSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse

⁴² *Ibid.*

⁴³ American Nurses Association and National Council of State Boards of Nursing. (2006). Joint Statement on Delegation.

⁴⁴ *The Random House Dictionary of the English Language*, 1987; second edition. S B Flexner, Editor.

⁴⁵ National Highway Traffic Safety Administration. (2007). *National EMS Scope of Practice Model*. Retrieved from www.nremt.gov.

⁴⁶ See MDCH section 20901 of 1978PA 368, MCL 333.20901et seq. and Executive Reorganization Orders Nos. 1996-1, and 2003-18, being MCL 330.3101.445.2001, and 445.2011)

⁴⁷ See MDCH section 20901 of 1978PA 368, MCL 333.20901et seq. and Executive Reorganization Orders Nos. 1996-1, and 2003-18, being MCL 330.3101.445.2001, and 445.2011) Definitions are taken from the license application :(a) Medical First Responder (MFR) - with 15 Michigan required credits for license, plus CPR; (b) Emergency Medical Technician basic (EMT) - 30 Michigan required credits plus 36 additional credits in any EMS category plus CPR. (c) Emergency Medical Technician – Specialist (EMT-S) (National Registration – Intermediate 85) – 36 Michigan required credits plus 36 additional credits in any EMS category plus CPR. (d) Paramedic – 45 Michigan required credits plus 27 additional credits in any EMS category plus ACLS. In addition, the Associate degree program in Emergency Medical Services allows the graduates to seek Michigan licensure and national certification as an EMT at all three skill levels. Michigan Compiled Laws Complete Through PA 26 & includes 28 & 31 of 2012.

⁴⁸ MCL: 333.20950 Michigan Compiled Laws Complete Through PA 26 & includes 28 & 31 of 2012d reference in Michigan Public Health Code to EMT licensure

⁴⁹ Greco, Rachel. (2012). Charlotte and Eaton Rapids EMS to Consolidate. *Lansing State Journal*. <http://www.lansingstatejournal.com/article/20120325/CHAR01/303250014/Charlotte-Eaton-Rapids-EMS-consolidate>

⁵¹ See definition of Michigan Education Requirements for EMTs above.

⁵² Michigan Public Health Code to EMT licensure.

⁵³ National Highway Traffic Safety Administration (2007). *National EMS Scope of Practice Model*. www.nremt.gov

MDCH – Task Force on Nursing Practice – Position Paper 6

Mitigate Human Factors in Patient Care Quality and Safety

Recommendation: To improve access to safe, high-quality healthcare for Michigan residents, the profession of nursing, nurses, nurse-employers, nurse-educators, and government regulators must collaborate to ensure that patient care is provided in care environments that take human factors into account,¹ thereby ensuring environments that are positive and safe for both patients and nurses. Because care environments are also work environments, both nurses and nurse-employers must accept their responsibilities to ensure a safe care/work environment. Nurse-educators must prepare nurses to appropriately manage human factors in all healthcare settings. Government regulators must take human factors into account in regulation of healthcare professions, facilities, and organizations, seeking changes in statutes and rules when needed to ensure a safe care/work environment that provides quality care and protects the public.

Summary of Issue

Nurses² provide care to patients in many different settings, from homes to primary care clinics to hospitals. In all of these settings, the care/work environment determines many aspects and requirements of nursing care and nursing work. However, nurses often find that the care/work environment does not take human factors into account, for either patients or nurses. The human factors³ often ignored in designing, operating, and administering healthcare/work environments^{4 5 6} include:

- the complexity (acuity)⁷ and volume of care required by patients and the needs of their families;
- the match between the nurse's own competencies, capacities, and experience and the needs of the patients⁸ and their families;
- fatigue impairment (mental, physical, and emotional), sleep deprivation, and compromised decision making/problem resolution;
 - nurses caring for many high-acuity patients or working repeated long shifts may get inadequate rest and become fatigued.⁹ Fatigued nurses make more errors and fail to catch the errors of others, compromising the quality and safety of patient care.¹⁰
 - nurses assessing their own human factors may fail to recognize the need to implement fatigue management strategies, engage in self-care efforts, or consider the physical, mental, and emotional variables that impact their ability to be vigilant, make critical decisions, and provide safe patient care
 - extended work hours, mandated work shifts, and shifts that start during normal sleep hours (e.g. 3am) have been associated with health care errors, as well as patient and nurse morbidity and mortality.¹¹
- the need for sufficient time between nursing work periods to manage fatigue, minimize sleep loss, and maximize alertness to provide quality nursing care to patient during the next work day; and^{12 13}
 - nurses may work long hours due to personal choice or employer mandate.^{14 15} Historically, nurses have been exempted from regulations limiting work hours.¹⁶ Michigan statutes and regulations are silent on the number of hours per day or per week that nurses may work in direct patient care, and most bedside nurses have become accustomed to working long hours and sleeping little.
- the need for a work culture of transparency, free from verbal, behavioral, physical, and sexual attacks on nurses, and including a safe place where nurses have support to report errors and harassment.
 - a hostile work environment can contribute to stress and fatigue,¹⁷ negatively impacting nurses' performance and therefore patient outcomes.¹⁸ Nurses and Nursing Assistive Personnel experience workplace violence, including, verbal, behavioral, physical, and sexual attacks¹⁹ from patients and their families, colleagues, and other health professionals/supervisors.²⁰ Nurses may be stressed, injured, or disabled by such attacks, removing them wholly or partially from the nursing workforce.²¹

“An overwhelming number of studies keep saying the same thing – once you pass a certain [fatigue] point, the risk of mistakes increases significantly. We have been slow to accept that we have physical limits and biologically we are not built to do the things we are trying to do.” [Ann Rogers, PhD, RN, FAAN, 2004]²²

Summary of Solution

To provide safe, high-quality care, the profession of nursing, individual nurses, nurse-employers, nurse-educators, and government regulators must share responsibility and collaborate to address the human factors in care/work environments that impact the quality and safety of patient care. This will require both individual and systems solutions:

- individual nurses have responsibility for coming to work rested, prepared, and ready to provide safe, quality patient care;
- individual accountability must be matched by nurse-employer organizational responsibility for providing systems that take human factors into account, a safe care/work environment, and a work culture that promotes safety, transparency, teamwork, and mutual respect;
- nurse-educators must prepare nurses to appropriately and productively manage human factors in all healthcare settings, protecting their patients and themselves; and
- government regulators must take human factors into account in regulation of healthcare professions, facilities, and organizations, seeking changes in statutes and rules when needed to ensure a safe care/work environment that provides quality care and protects the public.

This human factors solution will require all participants to cooperate and collaborate to improve the healthcare system.

Sub-Recommendations and Reasons

Recommendation 6a - Nurses: Human Factors Proposed Solutions

Individual nurses, supported by the nursing profession, their employers, and other members of the healthcare team, must address the human factors that impact patient care. Nurses must:

- acknowledge fatigue, the negative performance effects of fatigue, and the increased sleep hours required to avoid fatigue;^{23 24}
- learn to manage their own fatigue, engaging in effective sleep hygiene²⁵ practices at home and participating in employer-based fatigue management programs;²⁶
- come to work each day prepared and ready to provide safe, high-quality nursing care to patients;²⁷
- support a workplace culture change that eliminates extended work periods, i.e., mandatory overtime or excessive voluntary overtime, greater-than-8-hour shifts, double shifts, and 72-96 hour work weeks;²⁸
- learn the skill-sets and competencies to respectfully and productively interact with colleagues, supervisors, and patients/patient families, and thereby improve the care/work environment;^{29 30} and
- learn the skill-sets and competencies to serve on interprofessional care teams, with clear communication of patient information, mutual respect, and a uniform focus on safe, high-quality patient care.³¹

Reasons for Recommendation 6a - Nurses working extended hours, consecutive long workdays, double-shifts, or more than one nursing job are likely to become fatigued, failing to catch their own errors³² or the errors of other healthcare professionals, and compromising the quality and safety of patient care.³³ The care/work environment may require or permit long shifts, or rotating shifts. Nurses may prefer long shifts due to family needs, or because nurses need to work two jobs to increase their income. Despite these common practices, adults still require a minimum of seven (7) to eight (8) hours of sleep to be alert and vigilant.³⁴ Loss of only one hour of sleep has been shown to impair decision-making capability during the following day.^{35 36} As the 12-hour shift has become the norm in acute healthcare settings, many fatigued nurses not only struggle to provide safe patient care, but also have increased difficulty keeping themselves healthy and safe.^{37 38 39 40} The example of slight reductions (over the past 20 years) in the duty hours per day and per week of medical residents shows how difficult it is to change traditional work patterns, particularly if they are economically advantageous to either the employer or the worker.^{41 42} Despite strong recommendations to the contrary and at risk to patients and personal safety, “it is still common for medical residents to work over 100 hours per week for prolonged periods.”^{43 44}

Nurses also must decrease their own stress and improve patient care by seeking out and putting into practice courses that teach interaction and communication skills,⁴⁵ so that conversations and required interactions with

care-team members, colleagues, supervisors, and patients/patient families will become productive and respectful -- rather than the stressful, confused, exploitative interactions that decrease nursing retention and may lead to attacks on nurses and diminished quality of care for patients.

Safe, quality patient care requires that nurses be well-rested, alert to changes in patient condition, able to pick-up and correct errors in medication or treatment, and able to provide consistent, professional patient care day after day. Nurses owe this to themselves, their profession, and their patients.

Recommendation 6b - Nurse-Employers: Human Factors Proposed Solutions

Nurse-employers across all care/work environments, supported by their employees, owners, Boards, and regulators, must:

- integrate human factors analysis and management into the design, operation, and administration of care/work environments;^{46 47 48}
- support nurses in fulfilling their individual responsibilities [above]; support transforming the historical nursing cultural value of “work till you drop” into “come to work physically and mentally prepared to provide the best patient care;”⁴⁹
- adopt nurse staffing approaches that provide adequate staffing for safe, quality patient care⁵⁰ in all care/work environments;⁵¹
- provide a safe, healthy work environment⁵² for care delivery teams, including nurses, other health professionals, and support staff;
- institute and maintain a work culture that promotes and implements safety, transparency (including counselors and a safe place where nurses have support to report errors, harassment, and attacks), teamwork, and mutual respect;
- eliminate workplace violence through improved security and rules that codify zero-tolerance for verbal, behavioral, physical, or sexual attacks on nurses by patients and their families, colleagues/supervisors, or other healthcare professionals,⁵³ while encouraging nurses to report all attacks;
- establish as a strong workplace value, respectful, culturally appropriate communication among all members of healthcare teams; and
- use human factors analysis to develop educational programs to improve interprofessional teamwork, communication, and collaboration.⁵⁴

Reasons for Recommendation 6b - A huge body of human factors research literature supports the relationship among extended work hours, fatigue, and errors. In December 2011, the Federal Aviation Administration announced updated airline pilot work rules, “reflecting a better understanding of the need for rest and how night shifts ...can increase errors. Secretary Roy LaHood said ‘This is a big deal. This is as far as our government has even gone’ to protect the traveling public from pilot fatigue.”^{55 56} Nurse-employers must improve the conditions for provision of safe, quality patient care by enacting and implementing policies and rules based on best-practice and evidence-based approaches for limiting nursing hours worked per day and per week, with minimum rest periods before returning to patient care. This will result in fewer nursing errors, greater nursing interception of medication or treatment errors,⁵⁷ and improved patient and nurse outcomes.

Determination of nurse staffing is a multi-factorial process with factors that change frequently. Staffing decisions require an evidence-and-experience-based approach. Models for determining nurse staffing include all of the factors listed above, plus the fluctuating needs for provision of specific types of nursing care, day-to-day availability of qualified nurses, the availability of competent Nursing Assistive Personnel (NAPs), the need to maintain a continuous level of nurse staffing, the competencies, roles, and availability of other healthcare professionals, and the need to be cost-effective in decision-making. All of these “needs” have a direct relationship with patients’ need for safe, quality healthcare and nurses’ need for a care environment that is safe and supportive of nurses.⁵⁸ Care/work environments are major factors in the quality and safety of patient care in all settings, and must be a priority of nurse-employers, healthcare regulators, patients and families, nurses, and the public.

The rate of reported attacks against nurses has increased in all practice settings over the past five years; and attacks on nurses have become more violent, resulting in serious injuries and even death.⁵⁹ This is particularly notable in emergency departments, where waiting times are often long, waiting rooms are overcrowded, and triage of patients may lead to delayed treatment for some. Stress, fear, frustration, and anger on the part of patients, families, and even other healthcare professionals may lead to attacks on nurses in any healthcare setting, since nurses are the healthcare providers most often seen and they are perceived to control access to treatment and medications.⁶⁰ In addition, reported attacks may not be given appropriate attention by nurse-employers or the criminal justice system.⁶¹ If nurses work in unsafe conditions, they are less able to provide safe, quality healthcare to their patients, and may leave nursing entirely.⁶² The American Nurses Association 2011 Health and Safety Survey Report shows that some safety aspects of the care/work environment have improved during the past year; however, 52 percent of nurses, “say they have been verbally abused or threatened on-the-job within a year,” 34 percent of nurses are concerned about on-the-job physical assault, and 11 percent say they have been physically assaulted during the past year on-the-job.⁶³

When all members of the patient care team do not communicate respectfully and clearly, patient care suffers. When all members of the patient care team do not coordinate and collaborate to make their contribution to team-based patient care, safe, high-quality care is diminished. Nurse-employers and their in-house nurse education programs should use curriculum materials developed by the American Association of Colleges of Nursing to educate nurses and other health professionals to learn how to operate as interprofessional teams.⁶⁴

⁶⁵Health professionals in federally funded demonstration projects have shown that they can manage their human factors while working as interprofessional teams to provide patient care; these same techniques must be used to improve health professionals’ communications and cooperation in all care/work environments. Federal programs are already incentivizing interprofessional teams as one of the best mechanisms to improve the safety and quality of healthcare; in coming years, interprofessional teams will be the standard approach to high-quality care delivery. Collaboration and respectful, clear communications are the hallmarks of interprofessional teams.⁶⁶

Recommendation 6c - Nurse-Educators: Human Factors Proposed Solutions

Nurse-educators (teaching either in academic or agency-based programs), supported by their deans, administrators and supervisors, must create a learning environment (develop and implement curricula) that support nurses to achieve the competencies and skill-sets needed to appropriately manage human factors in all healthcare settings. These competencies and skill-sets include:

- management of fatigue;
- development of healthy care/work environments;
- management/development of positive interactions with colleagues, other health professionals, supervisors, and patients and their families;
- participation in functional interprofessional care teams;
- participation in respectful and culturally appropriate communications;⁶⁷ and
- management/development of violence-free and harassment-free education/care/work environments.

Reasons for Recommendation 6c - The process of learning how to manage the multitudinous human factors in healthcare environments must begin in nursing education programs. New nurses currently arrive in care/work environments with little or no preparation for the work stresses they will experience or the human interactions they will encounter. New nurses and practicing nurses must know how to manage their own fatigue and interact productively with their colleagues, their supervisors, and other health professionals, in addition to interacting with patients and their families. Many nurse-employers maintain nursing education programs in-house, with nurse-educators who keep nurses current on the ever changing healthcare field. Part of keeping current is learning effective ways of interacting with the human factors in the care/work environment, and developing the necessary skill-sets to manage interactions that may not be appropriate in that environment. Disrespect and attacks should not be ignored, but must be managed in ways that correct the situation, ideally without hurting any of the parties involved. Appropriate management of interactions with other nurses, physicians, supervisors, or patients and their families who approach a nurse with intent to harass, demean, or

attack that nurse requires competencies and skill-sets that must be added to nursing education, both in colleges and in practice.

Recommendation 6d - Government Regulators: Human Factors Proposed Solutions

Government regulators (particularly those dealing with healthcare and health professionals), supported by their administrators, elected officials, and their constituents must:

- take human factors into account in regulation of healthcare professionals, facilities, and organizations;
- review and assess existing statutes and regulations to determine if those statutes and regulations are obsolete, unnecessary, adequate to support the actions recommended above, or permissive of the actions recommended above; and
- take action either to remove obsolete, unnecessary statutes and regulations or to propose and enact statutes and regulations supportive and enabling of the actions recommended above.

Regulators must promote a care/work environment that is positive and safe for both patients and nurses.

Reasons for Recommendation 6d -

Nurses - Regulators must support nurses in maintaining their own health and readiness for practice. Nurses impact the health and safety of the public. Professionals with similar impact on the health and safety of the public (police, nuclear power plant engineers, and air traffic controllers, for example) have some degree of regulated duty hours and required rest hours.⁶⁸ Federal and (in some cases) state statutes ensure that passengers on airplanes, trains, and buses can expect their pilots, engineers, and drivers to be well-rested, alert, and capable of rapid problem-solving.^{69 70} These public protection strategies must be extended to nurses and the care/work environments in which nurses practice. Patients have a right to expect their healthcare providers to be alert to changes in patient condition, able to pick up and correct errors in medication or treatment, and consistently able to provide quality, safe care.⁷¹

Nurse-Employers - See regulatory aspects of care/work environments above. Regulators also must support nurse-employers in:

- adopting nurse staffing approaches that provide adequate staffing for safe, quality patient care in all circumstances;⁷²
- providing a safe, healthy work environment⁷³ for care delivery teams, including nurses, other health professionals, and support staff;
- generating and maintaining a work culture that promotes and implements safety, transparency (including counselors and a safe place where nurses have support to report errors, harassment, and attacks), teamwork, and mutual respect;
- eliminating workplace violence through improved security and rules that codify zero-tolerance for verbal, behavioral, physical, or sexual attacks on nurses by patients and their families, colleagues/supervisors, or other healthcare professionals,⁷⁴ while encouraging nurses to report all attacks;
- establishing as a strong workplace value, respectful, culturally appropriate communication among all members of healthcare teams; and
- using human factors analysis to develop educational programs to improve interprofessional teamwork, communication, and collaboration.⁷⁵

Nurse-Educators - Regulators must support nurse educators in developing and implementing new curricula that to provide nurses with the knowledge, competencies, and skill-sets to address and promote:

- management of fatigue;
 - development of healthy care/work environments;
 - management/development of positive interactions with colleagues, other health professionals, supervisors, and patients and their families;
 - participation in functional interprofessional care teams;
 - participation in respectful and culturally appropriate communications;⁷⁶ and
 - management/development of violence-free and harassment-free education/care/work environments.
-

Who Will Benefit from the Recommended Solution?

Patients and their families will benefit from reduced nursing fatigue, improved care and patient outcomes provided by nurses who are safe, well-rested, alert and vigilant to respond to changes in patient condition, detect errors, as well as intercept/prevent errors in patient treatment and medication, and physically and mentally able to provide safe, high-quality patient care. Patients will also benefit from care provided by an interprofessional healthcare team in a collaborative environment that promotes mutual respect and clear, effective communication among team members.

Nurses will benefit as they engage in self-care, become accountable for fatigue management, and experience improved health. Nurses will benefit from a safer and more positive work environment that insists nurses protect their own health as well as the health and safety of their patients by working hours appropriate under evidence-based nurse-staffing policies, and evidence-based nurse work and rest hours. Nurses also will benefit from increased interprofessional teamwork and collaboration, as well as respectful communication between all members of the patient care team to produce a positive and supportive work environment.

Nurse-employers will benefit from lower worker compensation costs, fewer employee sick leave days, increased nurse retention rates and lower nursing attrition when evidence-based nurse-staffing policies and evidence-based nursing work and rest hours are implemented. Nurse-employers will also benefit from improved federal payment for high-quality patient outcomes and patient care experiences as nursing care/work environments are made safe and interprofessional teams provide high-quality care.⁷⁷

Other healthcare professionals will benefit from a reduction in workplace violence and an improved workplace culture of respect, effective communication, and interprofessional collaboration supporting safe, quality patient care.

Background: Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP was composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met from December 2010 through April 2012, gathered information, consulted with state and national experts in nursing practice and policy, and considered issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Mitigating Human Factors in Patient Care Quality and Safety was determined by the TFNP to be high priority.

Appendix A – Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Care/work environment - Any environment in which patient care is provided (homes, long-term-care facilities, community-based clinics, hospice, and hospitals) and in which nurses work to provide patient care. The well-being of patients is inextricably linked to the well-being of the nurses caring for them.

Education/care/work environment - Any environment in which patient care is provided. Nurses work to provide patient care and nurses receive education on how to improve this environment through appropriate management of human factors.

Human factors - Aspects of being human (physical, perceptual, psychological, or behavioral) that are relevant to the system or item being analyzed. If the system or item must interface with humans, but human factors are not taken into account, the system or item will not function as intended. For example, if programming a blood pressure monitor requires that the programmer switch back and forth between pounds of pressure and kilograms of pressure, it is likely that errors will be made and the monitor will not function as intended.

Licensed Practical Nurse (LPN) - *LPN practice is a subfield of nursing. Therefore, practice as a LPN means practice of nursing under the delegation and supervision of a Registered Nurse (RN).⁷⁸ LPNs are responsible for their actions in the performance of delegated nursing functions, tasks and activities, while the supervising RN is accountable for the overall care and safety of the patient/client and the outcomes of nursing care.*

Nurse - *when used without modification or amplification, means only a registered nurse⁷⁹*

Nursing Assistive Personnel (NAPs) - *Individuals trained to function in an assistive role to the licensed registered nurse in providing patient care activities as delegated by the Registered Nurses (RNs), regardless of the title of the individual to whom nursing functions are delegated. RNs may delegate selected nursing functions to NAPs who have appropriate education and competencies.⁸⁰ The term NAP includes, but is not limited to, Certified Nursing Assistant, Nurse's Aide,⁸¹ Patient Care Technician, medication aides, orderlies, attendants, or technicians.⁸² NAPs are responsible for their actions in the performance of delegated nursing tasks and activities, while the supervising RN is accountable for the safety of the patient/client and the outcomes of nursing care.*

Nursing delegation - *the act of transferring to a competent individual the responsibility to perform a selected nursing function in a selected situation within an authorized scope of practice, the process for doing the work while retaining professional accountability for the outcome of care.^{83 84} [See full definition and process for nursing delegation in Recommendation #3]*

Practice of nursing - *The systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition.^{85 86} Nursing is a profession that is evidence-based, and requires an understanding of the human condition and applies the current science of professional caring⁸⁷ to health goals mutually established with patients goals.⁸⁸*

Scope of Practice for Registered Nurses⁸⁹ - *The complete Scope of Practice for Registered Nurses is stated in the most recent edition of the Nursing Scope and Standards of Practice of the American Nurses Association. The profession of nursing (Registered Nurses)⁹⁰ has one scope of practice that encompasses the full range of nursing practice, pertinent to general and specialty practice. The individual registered nurses' ability to engage in the total scope of nursing practice is dependent on their required education, competency, experience, role, and the population served.⁹¹ The authority for nursing is based on a social contract and relationship with the public.⁹² Nursing is a dynamic discipline that increasingly involves more extensive knowledge, technologies and patient care activities.⁹³*

End Notes

- ¹ National Academy of Engineering and Institute of Medicine of the National Academies (2005). *Building a Better Delivery System: A New Engineering/Health Care Partnership*; “Human-Factors Research”, pp.31-33; “The Human Factor in Health Care Systems Design”, pp.147-148.
- ² Nurse - when used without modification or amplification, means only a registered nurse licensed under this article to engage in the practice of nursing. See Recommendation and Position Paper 2, End Note 18; State of Wisconsin laws.
- ³ National Academy of Engineering and Institute of Medicine of the National Academies (2005). *Op cit.* “Human factors are those aspects of being human (physical, perceptual, psychological, or behavioral) that are relevant to the system or item being analyzed. If the system or item must interface with humans, but human factors are not taken into account, the system or item will not function as intended.”
- ⁴ Bae, SH, (2011) *Journal of Nursing Management* 19, 700-713. “Assessing the Relationships between Nurse Working Conditions and Patient Outcomes: Systematic Literature Review.
- ⁵ American Association of Critical Care Nurses (2005). *AACN Standards for Establishing and Sustaining Healthy Work Environments*. Healthy work environment initiative; a national movement that includes providing nurses with the individual skill sets needed to work toward a healthy work environment.
- ⁶ Employee Assistance Programs (EAPs), which may include nurse counselors to strengthen nursing competencies in communicating and interacting with others and with operating systems to improve the care/work environment (per TFNP member).
- ⁷ Acuity refers to the severity and complexity of the patient’s condition. As our population ages, patient acuity is going up.
- ⁸ Curley, Martha. (2007). *Synergy: The Unique Relationship between Nurses and Patients – The AACN Synergy Model for Patient Care*. The American Association of Critical Care Nurses and Sigma Theta Tau Nursing Honor Society.
- ⁹ Rogers, Hwang, Scott, Aiken, and Dinges, 2004. Scott, Hwang, Rogers, Nysse, Dean, and Dinges, 2007.
- ¹⁰ Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety, *Keeping Patients Safe*. The National Academies Press, Washington, DC, 2004. See pages 386 – 391 for discussion of the effects of nurse fatigue on patient care errors, made by nurses or by other healthcare professionals, and nurses’ ability to intercept errors before harm occurs.
- ¹¹ Gunnarsdottir, et al. 1995; Poissonnet, 2000; Geiger-Brown & McPaul, 2011; Barger et al, 2005; Scott et al; 2007; Rosa, 2001.
- ¹² Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety, *Keeping Patients Safe*. The National Academies Press, Washington, DC, 2004. [This entire book is relevant to the Human Factors position paper.]
- ¹³ Dinges et al., 1996; Rosa, 1995, 2001; Rosekind et al., 1995.
- ¹⁴ Issue Statement received by the Michigan Task Force on Nursing Practice: “Registered Nurses (RNs) are working multiple jobs and various shifts that often result in RNs working longer than 16 hours in a 24 hour period. Currently, some nurses are working 12 hour shifts at one facility and traveling to another to work another 8-12 hour shift without having slept. Creating a statewide policy prohibiting nursing from working longer than 16 hours within a 24 hour period (regardless of where those hours were worked) would increase patient safety and decrease fatigue among all nurses.”
- ¹⁵ Issue Statement received by the Michigan Task Force on Nursing Practice: “Stop mandatory overtime!”
- ¹⁶ “Unless specified in collective bargaining agreements, there are no federal (and only a few state) regulations restricting the number of hours a nurse can work in a 24-hour period or over a period of 7 days.” Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety. *Keeping Patients Safe*. The National Academies Press, Washington, DC, 2004. See pages 388-391.
- ¹⁷ Nursing job stress has been linked to: Burnout, frequent job turnovers, quitting before completing orientation; psychosomatic symptoms such as headaches, upset stomach, frequent illness, and general malaise; depression and anxiety; low job satisfaction and powerlessness; and other negative consequences -- poor quality of life, reduced productivity, impaired relationships with coworkers. (Almost & Laschinger, 2002; Boone, et al, 2008; Parsons & Stonestreet, 2004; Rosenstin & O’Daniel, 2005; Gauci-Borda & Norman, 2001; Kenkel, 2003; Manderino and Berkey, 1997; Parsons & Stonestreet, 2004). Referenced in *When Nurses Hurt Nurses*, Dellasega, 2011.
- ¹⁸ Joint Commission. (2008, July 9). Behaviors that undermine a culture of safety. *Sentinel Event Alert*, 40, 1-3.
- ¹⁹ Nurses experience physical or verbal attacks most frequently in Emergency Departments (EDs). A national survey of over 7,000 ED nurses shows that in 2010, over 53% of ED nurses experienced verbal abuse and almost 13% experienced physical violence. Patients were the perpetrators in nearly all incidents of physical violence and verbal abuse. In most cases of assault, nurses did not file a formal report (>86% in cases of verbal assault; 66% in cases of physical violence). See *Survey Finds No Letup in Violence against ED Nurses* at <http://news.nurse.com/apps/pbcs.dll/article?AID=/20111108/>.

-
- ²⁰ Vessey, J., Demarco, R., Gaffney, D., & Budin, W. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing*, 25(5), 299-306.
- ²¹ Wilson, *et al*, 2011.
- ²² Rogers AE, *et al*: The working hours of hospital staff nurses and patient safety. *Health Affairs*; 2004: 23(4):202-212.
- ²³ American Nurses Association (December 8, 2006). Position Statement: *Assuring Patient Safety: Registered Nurses' Responsibility in All Roles and Settings to Guard Against Working When Fatigued*.
- ²⁴ Rogers, A. as quoted in Joint Commission Alert below: "An overwhelming number of studies keep saying the same thing – once you pass a certain point, the risk of mistakes increases significantly. We have been slow to accept that we have physical limits and biologically we are not built to do the things we are trying to do."
- ²⁵ "Hygienic" means "conducive to good health, healthful." *The Random House Dictionary of the English Language, Second Edition, Unabridged*.
- ²⁶ American Nurses Association (December 8, 2006). Position Statement: *Assuring Patient Safety: The Employers' Role in Promoting Healthy Nursing Work Hours for Registered Nurses in All Roles and Settings*.
- ²⁷ The Joint Commission: Sentinel Event Alert (Issue 48, December 14, 2011). *Health care worker fatigue and patient safety*.
- ²⁸ Scott *et al*, 2006.
- ²⁹ Issue Statement received by the Michigan Task Force on Nursing Practice: "Behavior within nurse-physician relationships often is disruptive and negatively impacts patient safety. Developing physician-specific guidelines similar to the American Organization of Nurse Executives' guiding principles for excellent nurse-physician relations would improve current, negative interactions. Requiring organizations to a) implement a 360° review system for all healthcare providers, and b) require all providers to demonstrate competence in communication skills could improve behavior among health care providers. Improved relations among health care providers would positively affect the morale of hospital employees and increase patient safety."
- ³⁰ Issue Statement received by the Michigan Task Force on Nursing Practice: "Many clinical and professional nurses lack understanding of patients' cultural needs or beliefs. As the U.S. population becomes more diverse, continuing education credits on cultural competencies in nursing should be offered to increase the quality of nursing care. To promote cultural competency among nurses, a minimum of two hours of mandatory cultural education classes should be required every five years. This would be a simple, cost-effective method of reaching the entire nursing profession, and would improve the quality of care delivered to culturally diverse patients. This solution would increase patient satisfaction and promote a trusting patient-provider relationship."
- ³¹ Burckhart, PV, and Kirschling, JM (May 2011). *Implementing Interprofessional Education for Pre-licensure Students*. Interprofessional Education (IPE) and Team-based Competencies are new academic areas, rapidly developing curricula that include most of the competencies required to productively manage human factors.
- ³² While nurses generally intercept and correct most of their own errors and the medication and treatment errors of physicians, occasionally an extremely fatigued nurse makes a fatal error. An example is the medication error made by a Wisconsin labor and delivery nurse who had worked more than 24 consecutive hours with no rest for over 36 hours. The nurse filled two syringes with different medications for two different patients, and then confused the syringes, thus delivering a fatal dose of an anti-seizure medication to a teenage patient in labor. [See Aiken LH, Clarke SP, Sloan DM, *et al*. Hospital nursing staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association* 288(16):1987-1993.] This example illustrates the ease with which medication errors may occur, and the diminished likelihood that errors will be intercepted when nurses are extremely fatigued.
- ³³ Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety, *Keeping Patients Safe*. The National Academies Press, Washington, DC, 2004. See pages 384-391.
- ³⁴ Landis, C, Physiological and Behavioral Aspects of Sleep, in *Sleep Disorders and Sleep Promotion in Nursing Practice*, N Redeker and G McEnany, Editors. Springer Publishing Company, New York, 2011.
- ³⁵ Lamond and Dawson, 1998; Dinges *et al.*, 1996.
- ³⁶ Harrison and Horne, 2000.
- ³⁷ Gold, D, Rogocz S, Bock N, *et al*, 1992. Rotating shift-work, sleep and accidents related to sleepiness in hospital nurses. *American Journal of Public Health* 82(7):1011-1014.
- ³⁸ Lee K, 1992. Self-reported sleep disturbances in employed women. *Sleep* 15(6):493-498.
- ³⁹ Krueger, 1994. Dinges *et al.*, 1996.
- ⁴⁰ Extended work shifts (>12 hours) are not recommended for employees who: a) spend the majority of work time on their feet, b) are exposed to chemicals, c) work in a field that experiences staff shortages, d) have insufficient recovery time between

work periods, or e) are part of an employee category that includes a significant number of single parents. All of these characteristics are frequently found among nurses.

⁴¹ Institute of Medicine (2004), *Keeping Patients Safe*, pp 391-396.

⁴² Landrigan CP, et al: Effects of health care provider work hours and sleep deprivation on safety and performance. *Journal of the American Medical Association*, 2006;296: 250-258.

⁴³ Patton DV, Landers DR, Agarwal IT. 2001. Legal considerations of sleep deprivation among resident physicians. *Journal of Health Law* 34(3):377-417.

⁴⁴ In 2011, the Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME) recommended further reductions in the work hours of medical residents. Studies of the effectiveness of these recommendations will be forthcoming.

⁴⁵ See <http://www.aacn.nche.edu/education-resources/IPECReport.pdf> and <http://www.aacn.nche.edu/leading-initiatives/IPECProceedings.pdf>. These reports on Interprofessional Education and Interprofessional teams include information, guidelines, and curricula for educating nurses and other health professionals to productively interact in patient care teams while maintaining respectful relationships. These reports are source documents for the educational content needed by student nurses and practicing nurses.

⁴⁶ Bae, SH, (2011) *Journal of Nursing Management* 19, 700-713. "Assessing the Relationships between Nurse Working Conditions and Patient Outcomes: Systematic Literature Review.

⁴⁷ American Association of Critical Care Nurses (2005). *AACN Standards for Establishing and Sustaining Healthy Work Environments*. Healthy work environment initiative; a national movement that includes providing nurses with the individual skill sets needed to work toward a healthy work environment.

⁴⁸ Employee Assistance Programs (EAPs), which may include nurse councilors to strengthen nursing competencies in communicating and interacting with others and with operating systems to improve the care/work environment. (ref. NM)

⁴⁹ Landrigan, C. "We have a culture of working long hours, and the impact of fatigue has not been a part of our consciousness". Quoted in the Sentinel Event Alert of The Joint Commission (Issue 48, December 14, 2011).

⁵⁰ Issue Statement received by the Michigan Task Force on Nursing Practice: "Nurse staffing is currently based on staff and financial availability instead of patients' need and acuity. Patients are currently being placed at risk for injury, pressure ulcers, falls, infections, etc. Staffing should be based on patient needs and driven by quality and evidence-based practices. Michigan should mandate an evidence-based acuity system for all healthcare facilities to follow. By having a mandated staffing system, healthcare will be more patient-centered, with fewer in-hospital-acquired ailments and injuries."

⁵¹ The Joint Commission: Sentinel Event Alert (Issue 48, December 14, 2011). *Health care worker fatigue and patient safety*.

⁵² American Association of Critical Care Nurses (2005), *op cit*.

⁵³ Manderino, M & Berkey, N (1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing*, 3(1), 48-55.

⁵⁴ The federal DHHS-Health Services and Resources Administration and the Centers for Medicare and Medicaid Services have recently begun to incentivize interprofessional teamwork and collaboration, which require improved, respectful communication with all members of the patient care team.

⁵⁵ The Associated Press, "New FAA Rules to Help End Flying While Sleepy". *Lansing State Journal*, p10A, (12-22-2011).

⁵⁶ http://www.faa.gov/regulations_policies/rulemaking/recently_published/media/2120-AJ58-FinalRule.pdf

⁵⁷ Rogers, A., W. Hwang, L. Scott, L. Aiken, & D. Dinges. "Nurse Working Hours, Fatigue, and Patient Safety", *Health Affairs*, July 2004, vol.23 No. 4, 202-212.

⁵⁸ Taylor, J. et al, *Study Links Nurse Safety Issues with Patient Safety*. This study found that a nursing unit's safety climate was associated with both patient and nurse injuries, suggesting that patient safety and nurse safety may be linked outcomes.

See <http://news.nurse.com/apps/pbcs.dll/article?AID=20111107/>.

⁵⁹ *Survey Finds No Letup in Violence against ED Nurses* at <http://news.nurse.com/apps/pbcs.dll/article?AID=20111108/>.

⁶⁰ American Nurses Association, 2011. "In 2009, more than 50% of emergency center nurses experienced violence by patients on the job. There were 2,000 assaults and violent acts reported by RNs requiring an average of four days away from work. Of these acts, 1,830 were inflicted with injuries by patients or residents. From 2003 to 2009, eight registered nurses were fatally injured at work." *Statement on Workplace Violence* http://nursingworld.org/mainMenuCategories/Workplace_Safety/...

⁶¹ *Ibid*. "Although there is no federal standard that requires workplace violence protections, effective January 1, 2009, The Joint Commission on Accreditation of Healthcare Organizations created a new standard in the "Leadership" chapter [LD.03.01.01] that addresses disruptive and inappropriate behaviors. Additionally, there are several states that have enacted legislation or regulations aimed at preventing workplace violence (against nurses)." The ANA offers materials to be used in preventing or addressing workplace violence. See website above.

⁶² Wilson, *et al*, 2011.

⁶³ American Nurses Association. *ANA Survey Shows Improved RN Work Environment, Yet More Can Be Done to Promote Safety*. Press Release issued December 14, 2011.

⁶⁴ *Core Competencies for Interprofessional Collaborative Practice* <http://www.aacn.nche.edu/education-resources/IPECReport.pdf>; and *Team-Based Competencies, Building a Shared Foundation for Education and Clinical Practice* <http://www.aacn.nche.edu/leading-initiaves/IPECProceedings.pdf>. American Association of Colleges of Nursing, May 2011.

⁶⁵ Institute of Medicine, *The Future of Nursing, Leading Change, Advancing Health*. 2011. Appendix G. "In recent years, the University of Washington and many other educational institutions have experimented with different forms of interprofessional education. These approaches were grounded in the belief that collaboration requires understanding and respect for others' expertise as well as competence in one's own practice discipline."

⁶⁶ Benner P, Sutphen M, Leonard V, & Day L. *Educating Nurses: A Call for Radical Transformation*. Carnegie Foundation for the Advancement of Teaching (2010); p150. "For nurses, the error of making an unnecessary call (to a physician) is insignificant compared to the error of failing to call about a significant change in the patient's condition; for the physician, no action is usually safer than risky action. Students need to understand that this difference in perspective frequently leads to conflict between doctors and nurses, especially when they fail to appreciate the other's perspective, but the dialogue that occurs in making their respective cases usually results in better decisions by both parties on behalf of the patient."

⁶⁷ Issue Statement received by the Michigan Task Force on Nursing Practice: "Communications skills between nurses and other healthcare team members are lacking. This deficiency often causes adverse events and lateral violence between healthcare professionals. Communication skills and techniques are not sufficiently taught in nursing schools or hospital organizations. Improving communication among all healthcare team members would increase the quality of care and the safety of the patients. To improve communication patterns, residents of both medical and nursing programs should take courses together to build a mutual bond and respect that would carry over into practice settings. By leveling the playing field, nursing and medical students would be able to learn from one another and provide excellent patient care."

⁶⁸ Institute of Medicine (2004), *Keeping Patients Safe (op cit)*, see pages 396 – 403 for a discussion of police and nuclear power plant engineers hours; see pages 410 – 413 for a discussion of hours for pilots and air traffic controllers.

⁶⁹ Other occupational groups whose work hours and rest hours are regulated include: long-haul truckers, airline pilots, police, fire-fighters, and nuclear power workers. These are all occupations in which impairment of rapid, high-quality decision-making and action is dangerous to the health and safety of the public. Compared to these occupations, nursing has an equal or greater impact on the public's health, and therefore work hours and rest hours for nurses should be regulated.

⁷⁰ Federal Aviation Acting Administrator Michael Huerta on January 3, 2012, announcing a final rule that overhauls commercial passenger airline pilot scheduling to ensure pilots have a long opportunity for rest before they enter the cockpit: "Every pilot has a personal responsibility to arrive at work fit for duty. This new rule gives pilots enough time to get the rest they really need to safely get passengers to their destinations." See http://www.faa.gov/regulations_policies/rulemaking/recently_published/media/2120-AJ58-FinalRule.pdf.

⁷¹ There is no federal law regulating nursing work hours, although bills with this goal have been introduced several times. Almost 20 state legislatures have considered bans on mandatory overtime for nurses and other healthcare professionals. Bills prohibiting mandatory overtime for nurses have passed in California, Maine, New Jersey, and Oregon. No legislation, either proposed or enacted, addresses how long nurses may work on a voluntary basis. See Institute of Medicine, 2004, *op cit*, p 391.

⁷² The Joint Commission: Sentinel Event Alert (Issue 48, December 14, 2011). *Health care worker fatigue and patient safety*.

⁷³ American Association of Critical Care Nurses (2005). *AACN Standards for Establishing and Sustaining Healthy Work Environments*. Healthy work environment initiative; a national movement that includes providing nurses with the individual skill sets needed to work toward a healthy work environment.

⁷⁴ Manderino, M & Berkey, N (1997). Verbal abuse of staff nurses by physicians. *Journal of Professional Nursing*, 3(1), 48-55.

⁷⁵ The federal DHHS-Health Services and Resources Administration and the Centers for Medicare and Medicaid Services have recently begun to incentivize interprofessional teamwork and collaboration, which require improved, respectful communication with all members of the patient care team.

⁷⁶ Issue Statement received by the Michigan Task Force on Nursing Practice: "Communications skills between nurses and other healthcare team members are lacking. This deficiency often causes adverse events and lateral violence between healthcare professionals. Communication skills and techniques are not sufficiently taught in nursing schools or hospital organizations. Improving communication among all healthcare team members would increase the quality of care and the safety of the patients. To improve communication patterns, residents of both medical and nursing programs should take courses together to build a mutual bond and respect that would carry over into practice settings. By leveling the playing field, nursing and medical students would be able to learn from one another and provide excellent patient care."

⁷⁷ Kerin, A., and A. Aguirre (2005). “Improving Health, Safety, and Profits in Extended Hours Operations (Shiftwork).” *Industrial Health* 2005, 43, 201-208. Employer effects of fatigue reduction, including fewer sick days, lower workers’ compensation fees, and lower employee turnover.

⁷⁸ NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules. September 2009

⁷⁹ State of Wisconsin laws: Chapter 441. Subchapter I, Regulation of Nursing. 441.001 Definitions.

⁸⁰ NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules. September 2009

⁸¹ In Michigan, Certified Nurse’s Aides (CNAs) working in Long Term Care (Nursing Homes) have been regulated by the Bureau of Health Professions since 2000. CNAs are regulated under a federal statute, which requires that each state maintain a registry of CNAs, verify that they have 75 hours of training, and run a criminal background check on applicants; there are limited penalties for infractions of the federal statute. Many states require 120 hours of appropriate training for CNAs; Michigan should amend the MPHC to include CNAs and NAPs.

⁸² American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org/WhatisSafeStaffing/SafeStaffingPrinciples/PrinciplesforDelegationhtml.aspx#Nurse

⁸³ American Nurses Association. (2005). *ANA Principles for Delegation*. Retrieved 2011 from www.safestaffingsaveslives.org

⁸⁴ American Nurses Association (ANA) (2005) and National Council of State Boards of Nurses (NCSBN) (2006) Joint Statement on Delegation.

⁸⁵ *Occupational Regulation Sections of the Michigan Public Health Code*; MDCH Authority: P.A. 368 of 1978 as amended

⁸⁶ *Nursing Scope and Standards of Practice*; (2010). American Nurses Association

⁸⁷ Watson defines nursing “as a human science of persons and human health—illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (1988b, p. 54). In addition, she also views nursing as both a science and an art. *Watson, J. (1988b). Nursing: Human science and human care. A theory of nursing* (2nd printing). New York: National League for Nursing. (Original work published in 1985.)

⁸⁸ Watson, Jean, *Nursing: The Philosophy and Science of Caring*, University Press of Colorado, 2008

⁸⁹ The Scope of Practice for Registered Nurses is defined in the Michigan Public Health Code. The scope of practice for RNs may not be expanded by employers; however, employers may narrow the scope of practice for RNs either through policies or employee/labor agreements with other entities, such as unions.

⁹⁰ In this document, Scope of Practice should be understood to refer to the practice of Registered Nurses.

⁹¹ *Nursing Scope and Standards of Practice*; (2010). American Nurses Association.

⁹² *Nursing’s Social Policy Statement*; (2010). American Nurses Association.

⁹³ NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules. September 2009.

MDCH – Task Force on Nursing Practice – Position Paper 7

Increase Practice Efficiencies in Nursing & Healthcare

Recommendation: To improve access to safe, high-quality healthcare for Michigan residents, the profession of nursing and employers of nurses must improve practice efficiency by ensuring that patient-centered care (putting the needs of the patient first)¹ is the highest priority when decisions are made to design systems and operations. Nurses must be leaders, decision makers, and active participants in evidence-based designing, planning and restructuring of care processes (how nurses provide patient care)² and operational systems (how healthcare environments function)³ in all patient care environments to provide patient care efficiently. Federal and State rules and regulations must be modernized to improve efficiency, standards, and put the focus on safe, high-quality patient-centered care.⁴

Summary of Issue

Nationally and in Michigan, nurses (Registered Nurses)⁵ are the largest single group of healthcare professionals in all the settings where healthcare is provided. Patient-centered care puts the needs of the patient first. In providing patient-centered care, nurses are a critical resource whose expertise, time, and energy are sometimes squandered on current system inefficiencies and regulatory barriers. The complex and demanding nature of patient care and of hospitals, clinics, and homes as work environments provide many situations in which inefficiencies are likely to occur. This has negative effects on patient care outcomes and increases care costs.⁶ Practice inefficiency is related to:

- Flawed policies, operating systems, and procedures at the institutional level (hospitals, clinics, and community-based care services) that create an inefficient environment. Flawed policies (ex: hospital or community health Boards that do not include nursing), operating systems (ex: poorly designed, redundant charting systems, duplicate information systems), and processes (ex: redundant, inflexible approval processes), lead to “workarounds” (actions required to get the work done despite a policy, operating system, or procedure that might have been sensible 20-30 years ago, but now is obsolete, inefficient, and costly).⁷ Flawed policies, operating systems, and procedures lead to inefficient workflow – disruptions in the otherwise smooth flow of nursing functions and tasks required for safe, quality patient-centered care.⁸
- Disrupted workflow consumes nurses’ time and energy and impedes nurses’ capacity to provide safe, reliable, high-quality care. For nurses, workflow disruptions are caused by interruptions, inaccessible information/documentation, inaccessible healthcare professionals, lack of necessary medications and supplies, and lack of needed assistance. Disrupted workflow results in: less time to care for patients, inefficient use of personnel, delayed diagnostic testing, delayed discharges and transfers of patients, and compromised patient safety (ex: medication administration).⁹
- Poor communication (electronic, written, and verbal) and coordination among members of the patient care team and between different healthcare providers across all healthcare settings contributes to costly inefficiencies and sub-optimal care. This is particularly apparent during patient transitions from unit to unit within a healthcare facility, or from hospital to community-based care (primary care, home healthcare, rehabilitation center, or hospice). During such transitions,¹⁰ the patient may be responsible (by default) for transferring critical information from one healthcare provider to another. This may result in sub-optimal care due to flawed communication of essential information, leading to repeated tests, misunderstood directives, poor coordination of health services, or to a lack of healthcare services. In turn, this may result in readmission of the patient to the hospital, a costly outcome for all.
- Outdated Federal Medicare and Federal/State Medicaid rules and guidelines for hospitals, long term care settings,¹¹ clinics, and community-based services need updating. Many of these regulations are obsolete, burdensome, and prevent efficient utilization of healthcare resources.¹² Inefficient, inconsistent regulations impact healthcare providers in all healthcare settings, creating duplication, overlapping services, and conflicting regulatory requirements for healthcare providers and suppliers of equipment and services.¹³ In addition, Federal and State payment/reimbursement rules and systems

include many perverse incentives¹⁴ for inefficiency. This is notable when the patient is near death, but treatments acknowledged to be ineffective at this stage are continued. All of these factors create inappropriate utilization of resources and workload pressures that impede nurses in their efforts to provide optimal patient-centered care.¹⁵ Maximizing the efficiency and effectiveness of nurses is essential to healthcare system function and the promotion of safe, quality patient-centered care.¹⁶

Summary of Solution

Healthcare facilities and organizations must develop and implement policies and processes requiring that nursing leaders and appropriate direct-care nurses are participants in governance and decision-making for the patient care environment. Nurses must share decision-making in the identification, design, and implementation of needed changes and enhancements of all aspects of care delivery, from building design to institutional policies to nursing workflow.¹⁷ All participants in this process must use systems approaches, avoid “silo” thinking, and emphasize collaboration and teamwork. Healthcare operating systems (including communication systems and health information technology) must be optimized for patient-centered care. Transformation of the patient care environment will improve nursing practice efficiency and the delivery of safe, high-quality, patient-centered care.¹⁸

To improve practice efficiency, Federal¹⁹ and State rules, regulations, and reimbursement/payment systems must be modernized, eliminating unnecessary and obsolete standards and protocols, eliminating contrary incentives²⁰ that increase inefficiency and costs, freeing-up resources, and putting the focus squarely on providing efficient, safe, high-quality patient-centered care. The profession of nursing must engage the leadership of nurse-employers, such as hospitals, clinics, and community-based healthcare organizations, in creating a regulatory environment that supports and enhances efficient, safe, high-quality patient-centered care.

Sub-Recommendations and Reasons

Recommendation 7a - Engage Nurses in Governance, Decision Making, and Implementation

Healthcare facilities and organizations must develop and implement policies and processes requiring that nursing leaders and direct-care nurses are participants in governance and decision-making for the patient care environment. Ensure that nurses are “at the table” when patient-care buildings, operating systems,²¹ and technologies are designed and implemented. As clinicians, nurses own the responsibility to participate in decisions about design, workflow, new standards, implementation procedures, and adherence and accountability to new standards.²² The care environment, including technology, is a tool to leverage excellence in clinical practice and is directly related to efficient provision of safe, quality patient-centered care.²³ Efficient workflow in patient care coordination results in a seamless system that benefits nursing efficiency and the delivery of safe, high-quality, patient-centered care.²⁴

Reasons for Recommendation 7a - Engaging nurses as decision makers in all stages of systems analysis, design, operational planning, and implementation can create a more effective, efficient work environment that seamlessly and smoothly supports health professionals in the care of patients.²⁵ Better adaptation and adoption of new technology, communication and collaboration patterns, medication handling systems, care coordination, and workflow management will result when nurses and healthcare teams are involved from the design stage onwards. The same is true for modifications of current technologies and systems that are adapted for greater user acceptance.²⁶ If appropriate nurses with meaningful input are not engaged in decision-making, costly systems that decrease efficiency and effectiveness are a certainty. **Nurses should be the key designers and not the remodelers of the healthcare system.** Nurses who have substantial influence and control over their workday, workload, and workflow are more productive and efficient and have a higher level of job satisfaction.²⁷ Valuable nursing time that now is squandered on inefficient workflow may be returned to the nursing functions of patient-centered care.²⁸ This positively

influences patient outcomes, increases nurse satisfaction, helps address the developing shortage of nurses, and decreases costs.²⁹

See TFNP Position Papers 6 and 8 for additional discussion of these issues and solutions.

Recommendation 7b - Promote efficient communication and coordinated use of patient care information within and across all care settings

All patient care settings (hospitals, long-term care, clinics, and community-based healthcare providers) must engage nurses (as described in 7a) in the design, specification, and implementation of communication and documentation systems for electronic health information. Electronic/digital communication of complete, accurate patient care information must be seamlessly integrated into clinical practice.³⁰ Coordinated use of this patient care information must be organized - ideally at the regional level - so that all patient care settings have all the information they need to provide safe, high-quality patient-centered care.³¹ Healthcare professionals and their employers must make professional communication, coordination, and collaboration highly valued aspects of professional behavior and patient care functions.

Reasons for Recommendation 7b - Inputting and accessing patient care information consumes the time and energy of nurses and other healthcare professionals, frequently without improving the availability of patient care information when it is needed. Patients transitioning from one care environment to another (hospital to primary care and home care, for example) or from one healthcare provider to another, need to have full information on their hospital care and after-care needs sent to their primary care provider and home health provider. Nurses attempting to provide quality discharge planning often find patient care information unavailable or incomplete, necessary authorizations and sign-offs unavailable, and coordination of care with community-based providers difficult or impossible. This may result in patients leaving the hospital with printouts of the incomplete information available, and advice to give this information to their primary care provider when they get an appointment. The disconnect between hospital care and coordinated care in the community setting is a major factor in hospital readmissions within one month of discharge, a costly failure of communication, coordination, and collaboration.^{32 33} Improved information systems and regional health information organizations are a target of recent federal incentives, as are high-value health care organizations, such as Accountable Care Organizations (ACOs); all of these initiatives encourage care coordination, and improved communication and collaboration among healthcare professionals - all in the service of safe, high-quality patient-centered care.³⁴

See TFNP Position Paper 6 and 8 for additional discussion of these issues and solutions.

Recommendation 7c - Modernize Federal and State Policies and Rules

To improve practice efficiency, Federal³⁵ and State rules, regulations, and reimbursement/payment systems must be modernized, removing unnecessary and obsolete standards and protocols, eliminating contrary incentives that increase inefficiency and costs, freeing resources, and putting the focus squarely on providing efficient, evidence-based, safe, high-quality patient-centered care. The profession of nursing must engage the leadership of nurse-employers, such as hospitals, clinics, and community-based healthcare organizations, in creating a regulatory environment that supports and enhances efficient, safe, high-quality patient-centered care.

To improve practice efficiency and reduce waste, Federal and State statutes, rules and regulations and reimbursement/payment systems must be modernized and reflect current evidence. Unnecessary, conflicting, and obsolete standards and protocols must be eliminated, as well as contrary payment incentives that increase inefficiency and costs. Nurse-employer policies and processes often are grounded in Federal/State rules and reimbursement/payment systems. Changes at the Federal level will permit nurse-employers to engage nursing expertise and the expertise of all members of the care team in a

systems improvement approach (avoiding “silo” thinking) to reformulate policies and procedures to support efficient nursing provision of safe, high-quality patient care. The federal government has recently proposed regulatory changes that will make hospital operations more efficient and flexible, thus saving funds and improving processes.³⁶ State government and nurse-employers must urge support of these federal regulatory changes and similar federal and state regulatory improvements, and make corresponding changes in statutes, regulations, and policies at the state and institutional levels.

Reasons for Recommendation 7c - In hospitals, federal rules require that pre-existing pressure ulcers are documented on admission. The CMS federal rules require assessment and documentation be performed and signed by the physician, nurse practitioners or physician assistant. For years, assessment and documentation have been performed by the registered nurse in most health care settings. This demonstrates that the CMS rule does not reflect current evidence or practice.

Another example of inefficiency is the requirement that a physician, within a short period of time, must sign an order for a patient whose freedom of movement must be restrained in order to permit or continue treatment; for example, a patient might have mittens placed on their hands to prevent their removal of an IV. Registered Nurses (RNs) have the competencies required to make these decisions to ensure patient safety.³⁷ There are many instances of this physician “gatekeeper” role, which is frustrating and burdensome for physicians, nurses, patients, and their families. These are examples of inefficiencies that impact patient safety.

Regulatory and policy reforms at all levels will improve workflow and help health care professionals operate more efficiently by reducing regulatory burden.³⁸ The influence of federal/state reimbursement and payment rules on healthcare provider policies and actions is inevitable, and (as in the examples above) will continue to provide contrary incentives for provision of inefficient and unnecessary care. Nurses must support implementation of data-sharing standards across systems to improve the movement of electronic health information from one entity to another, and increase the availability of patient information.³⁹ Support of these federal initiatives will remove barriers to the improved quality and efficiency of healthcare, decrease costs, and improve patient satisfaction.⁴⁰ The federal government’s proposed regulatory changes (in the CMS proposed Conditions of Participation⁴¹) will promote healthcare efficiency and decision making based on the clinical needs of patients, rather than financial considerations. Decreasing the regulatory burden and aligning incentives that promote coordinated care and improved quality will have a positive impact on patient care outcomes, safety, and patient/family satisfaction.⁴²

See TFNP Position Paper 6 and 8 for additional discussion of these issues and solutions.

Who Will Benefit from the Recommended Solution?

- The public (patients and families) will benefit from:
 - healthcare teams that communicate and collaborate seamlessly to improve patient care;
 - care coordination that transitions patients from hospital to community-based care with accurate, complete information and all needed services;
 - patient information systems that are more efficient, accurate, and effective in supporting safe, quality care; and
 - increased respect for the healthcare decisions of patients and their legally designated health representatives.
- All care environments (hospitals, clinics, and community-based healthcare) will benefit from greater efficiency and effectiveness of shared-information systems, care coordination and collaboration management, patient-centered care, and nurse retention across all healthcare settings.

- Individuals, employers, and governments purchasing care will benefit from less waste of healthcare professionals' time, expertise, and energy. Improved operating and workflow systems will decrease patient care errors, inefficiencies (such as re-hospitalizations), and ultimately decrease costs.
 - Nurses will benefit from operating and workflow systems that support patient care rather than impede patient care. Frustration, wasted time and energy, and nursing turnover will all decrease.
 - Nurse-employers will benefit from improved nurse productivity, decreased nursing turnover, fewer sick days, lower workers compensation costs, and higher retention of experienced nurses.
 - Other healthcare providers will benefit from improved coordination of care, fewer frustrating hold-ups, delays of care, and less wasted time and energy.
-

Background: Michigan's strategic plan for addressing the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP was composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met from December 2010 through April 2012, gathered information, consulted with state and national experts in nursing practice and policy, and considered issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Increasing Practice Efficiencies was determined by the TFNP to be high priority.

Appendix A – Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Nurse - *When used without modification or amplification, means only a registered nurse.*⁴³

Nurse-employers - Are institutions, organizations, or individuals who employ nurses to practice nursing. Typically, nurse-employers are home-health organizations, long-term care facilities, hospices, community clinics, physician practices, hospitals, and mental health agencies or organizations.

Patient care systems - Include all the buildings, equipment, educated and trained healthcare professionals, ancillary personnel, and organizational structures that make it possible to provide patients with safe, quality care.

Patient-centered care - Care that puts the needs of the patient first.

Practice efficiency - To practice the provision of healthcare in such a manner as to provide safe, high-quality patient-centered care, while expending only the necessary amounts of time, energy, equipment, supplies, and other resources.

Practice of nursing - *The systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition.*^{44 45} *Nursing is a profession that is evidence-based, and requires an understanding of the human condition and applies the current science of professional caring*⁴⁶ *to health goals mutually established with patients goals.*⁴⁷

Workarounds - A bypass of a recognized problem in a program or system without eliminating the problem. [Merriam-Webster]

End Notes

¹ Institute of Medicine (2010). *The Future of Nursing: Leading Change, Advancing Health*, p. 51. “As outlined in *Crossing the Quality Chasm* (IOM, 2001), patient centered care is built on the principle that individuals should be the final arbiters in deciding what type of treatment and care they receive.”

² IOM (2004): *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Changes in approaches to care delivery, pp 79-80.

³ IOM and NAE (2005): *Building A Better Delivery System: A New Engineering/Health Care Partnership*.

⁴ Cartwright-Smith, L, Thorpe, JH, & Rosenbaum, S. Easing the Pathway to Accountable Care Organizations: Final Administration Policy, *BNA's Health Care Policy Report*. The Bureau of National Affairs, Inc. 11/21/2011; p2.

⁵ Nurse - when used without modification or amplification, means only a registered nurse. See Position Paper 2, End Note 18; State of Wisconsin laws.

⁶ Hendrich, Ann, Chow, M, Skierczynski, B, and Lu, Z. “A 36-Hospital Time and Motion Study: How Do Medical-Surgical Nurses Spend Their Time?” *The Permanente Journal*, Summer 2008: v12; 3.

⁷ Webster's dictionary definition of *workaround*: “a plan or method to circumvent a problem without eliminating it.”

⁸ Issue statement submitted to the Michigan Task Force on Nursing Practice: “In acute care settings, nurses often direct physicians on patient assessments and determinations on post-discharge care. Even though nurses are directing physicians on these issues, a physician's signature is still required to complete and legitimize the order. Nurses should be able to order: home healthcare visits; stays in extended care facilities and hospice; and durable medical equipment without a physician sign-off. This nursing practice barrier delays patient care or discharge, while increasing costs and frustration for the patient and patient's family. Updating the language in current Michigan statutes to eliminate such barriers would allow nurses to practice to the full extent of their education and training and would help reduce healthcare costs and increase efficiency.”

⁹ Burnes Bolton, Linda, Gassert, C A, and Cipriano, P F. “Smart Technology, Enduring Solutions: Technology Solutions Can Make Nursing Care Safer and More Efficient. *Journal of Healthcare Information Management (JHIM)*, Fall 2008: v22;4.

¹⁰ Healthcare professionals also encounter transitions – from education to practice, from one healthcare setting/practice to another, or from one unit to another within a hospital or other healthcare institution. These transitions often result in poor communication and coordination, disorientation, and inefficiency, leading to sub-optimal care. The Michigan Nursing Education Council is actively working on the transition from nursing education to practice. To improve patient care quality and outcomes, the employers of healthcare professionals must take steps to ameliorate the negative effects of transitions for health professionals in their employ.

¹¹ Many long-term care and skilled nursing facilities have upgraded their facilities and staffing to become eligible to provide rehabilitation services. Since patients now are discharged from hospital treatment at early stages of recovery, there is strong demand for a care setting where patients may finish recovery and receive rehabilitation services – prior to returning to their homes. Long term care facilities offering rehabilitation services may also offer hospice services.

¹² DHHS Center for Medicare & Medicaid Services (CMS), *Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation*. Advanced copy of proposed rule, released October 21, 2011.

¹³ All healthcare providers and vendors of equipment and services are affected by federal and state rules and regulations. For example, stand-alone kidney dialysis (end-stage renal disease treatment) facilities, durable medical equipment suppliers, and specialized surgical centers must all comply with federal regulations from the Center for Medicare & Medicaid Services (CMS). Different types of healthcare providers and vendors have different rules, which sometimes are inconsistent and cause confusion and delays for all parties.

¹⁴ “*Perverse incentives*” is a phrase taken from health economics, where it means an incentive that produces an effect contrary to that desired. The Random House dictionary definition of *perverse* is: “willfully determined or disposed to go counter to what is expected or desired.” This paper will use the substitute phrase “*contrary incentives*” from this point onwards, to avoid misunderstandings or misinterpretations.

¹⁵ Hendrich, *op cit*.

¹⁶ *Ibid*.

¹⁷ Hendrich, *op cit*.

¹⁸ *Ibid*.

¹⁹ DHHS-CMS, *op cit*.

²⁰ National Academy of Engineering & Institute of Medicine (2005). *Building a Better Delivery System: A New Engineering/Health Care Partnership*; p. 114, p. 147, p. 229.

²¹ Systems improvements identified and specified by nurses in collaboration with other members of the patient care team must be made in the process and technology of: patient care documentation; patient care team communication and collaboration; medication handling; care coordination; and workflow management. These systemic elements of the care environment must be

determined largely by input from the health care team with nurses in leadership roles, since nurses must productively and continuously interact with these elements in the provision of patient care.

²² Comment (Oct. 2011), P. Natale, *Senior Vice President and Chief Nursing Officer Emerita*, Detroit Medical Center.

²³ American Nurses Association, *Nursing's Social Policy Statement: The Essence of the Profession*. 2010:pp3-19.

²⁴ Hendrich, *op cit*.

²⁵ *Ibid*.

²⁶ Burnes, *op cit*.

²⁷ Turisco, Fran, and Rhoads, Jared. *Equipped for Efficiency: Improving Nursing Care Through Technology*, Prepared for California HealthCare Foundation, December 2008.

²⁸ *Ibid*. Flawed workflow results in inefficient use of personnel, delays in care, and compromise of patient safety and privacy. Process improvements can greatly reduce the fragmentation and duplication in documentation that often is exacerbated by regulatory and public policy requirements for documentation. Medication handling processes can be affected by fragmentation of the informatics infrastructure. Medication administration is improved by a seamless system providing accurate and timely information about the patient, including patient identification, order verification, allergies, laboratory values, and potential reactions and preferences.

²⁹ Turisco, *op cit*.

³⁰ Bohmer, RMJ (2011). The Four Habits of High-Value Health Care Organizations, *The New England Journal of Medicine*, December 2011: 365;22.

³¹ The Mi STA*AR project (Michigan State Action on Avoidable Rehospitalizations) is an effort of the Michigan Health and Hospital Association and MPRO, Michigan's quality improvement organization, funded by the Commonwealth Fund. The project is focused on developing community collaborative networks of providers and advocates to improve community care transitions and thus reduce rehospitalizations. Over 65 hospitals (out of 144 in the state) have participated.

³² Issue statement submitted to the Michigan Task Force on Nursing Practice: "Some hospital discharge planning systems do not focus on assisting the patient and family when planning for discharge and there is much confusion and miscommunication between healthcare staff regarding a patient's discharge. In some hospitals, medical staff may refuse to type systems discharge orders into the electronic medical record system. This creates multiple record systems without communication and collaboration between hospital staff and patients. This lack of communication has led to instances where patient medication histories are not taken into account in planning for discharge. In order to solve these communication and collaboration issues, financial incentives and disincentives need to be created in the following ways: consistent monitoring of readmission rates and dissemination of information to all payers in the hospital payment strategies; require at least one home health nurse assessment visit or phone call within 2 days of discharge for major surgery patients; and require, for reimbursement, that orders (discharge and others) be input to the EMR, when capability exists. By following the above steps, patients and their families, plus hospital discharge planners will be well informed of the proper procedures post surgery, hospital readmission rates should decrease, and the Michigan healthcare system will be more efficient."

³³ Issue statement submitted to the Michigan Task Force on Nursing Practice: "Upcoming Medicare rules will require healthcare systems to reduce the frequency of rehospitalizations within 30 days of a previous stay. Currently, 25% of patients with heart failure are readmitted within 30 days. In order to reduce readmission rates for patients with heart failure, nurses, discharge planners, nurse administrators, and Advanced Practice Registered Nurses (APRNs) must work in collaboration with physicians and other healthcare professionals to focus on increasing patient education and self care so that transition issues from hospital to home, home care, and care facilities can be reduced. By educating patients and monitoring self care adherence, considering concerns for caregiver's roles, patients, and families, healthcare professionals working in collaborative teams can be successful in bridging the care transition between all healthcare facilities and reduce readmission rates for patients."

³⁴ Bohmer, RMJ. *Op cit*.

³⁵ DHHS-CMS, *op cit*.

³⁶ DHHS-CMS, *op cit*.

³⁷ See TFNP Position Papers 1 and 2 for a discussion of Registered Nurses and APRNs practicing to the full extent of their education and competencies.

³⁸ DHHS-CMS, *op cit*.

³⁹ Burnes, *op cit*.

⁴⁰ *Ibid*.

⁴¹ United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42CFR Parts 482 and 485 [CMS-3244-P], RIN 0938-AQ89, Proposed Rule: *Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation*. October 18, 2011.

⁴² DHHS Center for Medicare & Medicaid Services (CMS), *Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment; Ambulatory Surgical Center Payment; Hospital Value-Based Purchasing Program; Physician Self-Referral; and Patient Notification Requirements in Provider Agreements*. Final rule with comment period.

⁴³ State of Wisconsin Laws, *op cit*. See Position Paper 2, End Note 18.

⁴⁴ *Occupational Regulation Sections of the Michigan Public Health Code*; MDCH Authority: P.A. 368 of 1978 as amended

⁴⁵ *Nursing Scope and Standards of Practice*; (2010). American Nurses Association.

⁴⁶ Watson defines nursing “as a human science of persons and human health—illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (1988b, p. 54). In addition, she also views nursing as both a science and an art. *Watson, J. (1988b). Nursing: Human science and human care. A theory of nursing* (2nd printing). New York: National League for Nursing. (Original work published in 1985.)

⁴⁷ Watson, Jean, *Nursing: The Philosophy and Science of Caring*, University Press of Colorado, 2008

This page intentionally left blank

MDCH – Task Force on Nursing Practice – Position Paper 8

Advance Technology in Nursing Practice and Healthcare

Recommendation: To improve access to safe, quality health care for Michigan residents, nurses and nursing leaders must be active decision makers in selection, design, development, implementation, and evaluation of technology-based systems and devices. Healthcare Technology (HT) must support the delivery and documentation of nursing patient care in a manner that increases the quality, coordination, and efficiency of care delivery.

Definition: Healthcare Technologies [HT] (including health information technology, HIT), are tools that have the potential to transform patient care. HT includes, but is not limited to: electronic devices, electronic teaching tools (for students, professionals, and consumers), electronic monitoring systems and devices, and electronic health records. HT impacts patient care received and must support the standards of practice in all practice settings. Health information technology is a tool that allows information to be accessed independently, regardless of location, allowing individuals to communicate to benefit patient care and outcomes.

Summary of Issue

In Michigan, 100,000 people are expected to turn 65 every year for the next 10-20 years.¹ As the population ages, Michigan healthcare providers will be responsible for caring for an increased older population who require more health care due to multiple chronic diseases,² such as diabetes, asthma and heart disease. Management of multiple chronic conditions is burdensome for both patients and healthcare providers, due to care costs and provider shortages.^{3 4} The potential for healthcare technology to assist in patient care management has not been maximized to date.

Many healthcare provider communication systems need modernization. Hospitals in the United States collectively “waste” \$12 billion annually on poor communication practices; this equates to an average loss of \$4 million annually for a 500-bed acute care hospital. Registered Nurses (RNs) spend large amounts of time on communications tasks across all care settings, including hospitals, home health, primary care, patient centered medical homes, long term care, etc. These tasks impact expenses, patient experience of care, patient satisfaction ratings, nurse job satisfaction, nurse turnover, and nurse stress.⁵

Nurses⁶ constitute a major healthcare technology user-group, who should be engaged in healthcare system efforts to fulfill federal meaningful use requirements, which carry federal financial rewards. However, appropriate nursing involvement in the selection, design, development, implementation, and evaluation of Healthcare Technology (HT) systems is not routinely practiced. Current experience also shows new HT systems often have been designed, purchased, and implemented without due consideration of nursing care and workflow.⁷ For example, some Electronic Health Record (EHR) systems require multiple log-in screens, disrupting the transition from one patient record to another, wasting time, and frustrating users. Because nurses are required to use these inefficient systems, they often are the most familiar with systems’ operations, and there are reports that nurses frequently are requested to enter data for other health professionals. This needlessly takes nursing time away from patient care.⁸ Technologies not properly integrated into nursing workflow require nurses to maneuver around systems, resulting in delayed patient testing, transfers, and treatment, therefore reducing the quality of patient care.

[See TFNP Position Papers 6 and 7 for additional discussion and examples.]

Summary of Solution

Nurses have a professional responsibility to evaluate technologies that impact patients’ care and safety.⁹ Nurses must be engaged meaningfully in the selection, design, development, implementation, and evaluation of all HT systems to improve HT selection decisions, efficient care system operations, patient outcomes, and nursing work environments.¹⁰ Nurses provide essential clinical knowledge that HT systems must incorporate to increase the quality and efficiency of patient care. When implemented with clinical

knowledge of workflow, HT tools have positively impacted care quality and safety, modernized communication techniques, and increased patient and employee satisfaction in all places where healthcare is provided (care settings).¹¹

With healthcare information following the patient from care setting to care setting, the healthcare industry is transitioning from episodic care of patients during acute illness to care across the patient's lifespan.¹² Electronically capturing standardized, sequential health data across an individual's lifespan, allows data to be analyzed to identify practice trends and assess appropriate treatment. The use of HT tools to improve health and healthcare will increase as these tools are adapted to healthcare workflow and are used to increase transparency for patients.

Aggregate data from well-designed Health Information Technology (HIT) systems will allow evidence-based treatments to be identified and developed into best practices for the healthcare industry. Studies have shown that improved and more efficient nursing care, better care coordination, increased patient safety, and improved patient outcomes occur in systems that effectively implement Electronic Health Records.¹³ The American Recovery and Reinvestment Act¹⁴ (ARRA) and the Patient Protection and Affordable Care Act (ACA) began the healthcare transition to more patient-centered, safe, quality healthcare EHR practices.^{15 16} Appropriate utilization of HIT will help reduce healthcare costs in Michigan while improving the health of Michigan residents.

Nursing engagement in the selection, design, development, implementation, and evaluation of HT systems¹⁷ and nursing accountability for use of HT systems will improve the effectiveness of the system to increase safe, quality patient care. HT devices and systems must be structured to gather and analyze standardized data related to nursing care functions. Federal initiatives to reimburse/pay on the basis of healthcare quality will reinforce the need for efficient, effective HT systems that capture information about nursing care functions.^{18 19}

Sub Recommendations and Reasons

Recommendation 8a - Effective Healthcare Technology (HT) Development

To improve access to safe, efficient quality healthcare for Michigan residents, nurse-employers must engage appropriate nursing expertise in the selection, design, development, implementation, and evaluation of all health technology systems and future upgrades. Usage of healthcare technology must be analyzed in terms of how the technology will advance nursing standards of practice and patient outcomes, while improving communication among healthcare providers in all healthcare settings.

Reasons for Recommendation 8a - Michigan will continue to experience access-to-care issues unless healthcare practices in all care settings are modernized to include HT systems and devices. Nurses are the main care providers in virtually all healthcare settings, therefore the expertise of experienced nurses is crucial in the selection, design, development, implementation, and evaluation of all HT systems and devices. By incorporating experienced nurses and other providers in the process of designing, developing, and implementing patient care monitoring and reporting systems, care is improved and practice inefficiencies are avoided.^{20 21 22} Technology systems guided and structured by nurses will benefit nursing assessments of complex patients, and increase flexibility in handling the changing needs of patients and the profession. Nursing and clinical workflow must drive the development of HT systems to effectively provide useful information, foster collaboration, and assure communication among all members of the patient care team.

Increased RN employee satisfaction and utilization of new HT systems occurs when nurses are engaged in the development and implementation of HT systems.^{23 24} A nurse leader in a major Michigan hospital system states, "Technology is merely a tool to leverage excellence in clinical practice and therefore, clinicians own the responsibility to participate in its design, workflow, decisions about new standards, implementation, and accountability of practitioners to adhere to the redesigned standards."²⁵ As clinical

workflow drives the development of HT, the resulting workflow facilitates the gathering of information, and collaboration and communication among members of the patient care team, regardless of their location. Patients also become more engaged in their healthcare, allowing HIT devices and systems to serve as electronic health-literacy teaching and information tools.

Recommendation 8b - Integrating Healthcare Technology (HT) Systems into Practice

The implementation of new HT systems is a transformational change, requiring resources to sustain long term use.²⁶ Nurse-employers must invest time and resources to support ongoing education of healthcare professionals when new HT programs are implemented or updated. This will promote successful adoption of HT systems,^{27 28} and will be easier to accomplish in large nurse-employers than in small ones, which may need to create partnerships to reach this goal.

Reasons for Recommendation 8b - Healthcare systems in Michigan will continue to waste resources on inefficient applications of HT systems unless nurse-employers properly educate their employees on the utilization of new HT devices and systems. Utilizing HT systems and devices in practice settings requires continuous support and is an ongoing learning process. Nurse-employers, who do not realize that technology implementation is a long-term commitment requiring continuing staff education, find that their HT system does not reach its maximum potential.²⁹ Many useful features of HT systems are not being utilized because some healthcare professionals do not know how to integrate the technology into their daily workflow. Some members of the patient care team refuse to use EHR systems³⁰ or other HT system devices. This refusal results in data loss, data inaccuracy, delayed data entry or duplicate data entry into incompatible systems, causing an incomplete patient care record for use by all members of the care team. When all members of the patient care team are properly utilizing all HT systems and devices, real-time patient information is available, resulting in better coordination of care. Individual healthcare providers and executives also can view data and pull reports that analyze the economics of their HT utilization and benefits seen from improved care coordination.

A study by the Center for Health Information and Decision Systems at the University of Maryland showed that an average of 36% of all healthcare funds is spent on inefficient uses of nursing time.³¹ Nurses often serve as intermediaries between other healthcare professionals and HT systems. If all hospital systems educated all professional staff on the features of HIPAA-compliant HT systems and require the use of those systems, inefficient expenditures of nursing time could be reduced. Nursing time is a precious resource that must be allocated primarily to patient care. The American Hospital Association included Electronic Health Record competency in their standards for hospital-based Advanced Practice Registered Nurses (APRNs) and RNs, which reinforces the need to improve the HT competencies of all healthcare professionals.^{32 33} Additionally, mechanisms for health professional input on needed enhancements to HT systems must be developed and implemented so that dissatisfied users have a channel to impact infrastructure and improve the current system.

Home Health, Hospice, and Veteran Affairs operations already have shown proven benefits to the integration of HT into nursing workflow. These healthcare settings are emerging as environments in which HT and communication technologies facilitate nursing care, resulting in increased patient care benefits and satisfaction scores.^{34 35 36} Home Health, Hospice, and Veteran Affairs have utilized remote monitoring equipment that permit the collection of standardized electronic data from patients at home. Healthcare providers are then able to evaluate changes in the patient's health data in real time and intervene if needed. When multiple healthcare providers can share data and collaborate to make treatment decisions, overall patient care improves.

Rather than reinventing the wheel, the successful HT integration approaches of healthcare systems should be recast to meet the needs of smaller healthcare providers.³⁷

Please see Appendix B, Case Statements I & II for HIT implementation and infrastructure suggestions.

Recommendation 8c - Healthcare Technology Requirements for Healthcare system Changes

To improve access to safe, quality healthcare for Michigan residents, nurse-employers must require all health information technology systems to accurately document nursing functions and interventions related to patient care and patient outcomes in a standardized manner to meet federal requirements for reimbursement/payment.

Reasons for Recommendation 8c - Nursing functions and interventions must be accurately recorded,³⁸ so that healthcare organizations are able to document the complete influence of patient care received on patient outcomes. New federal pay-for-performance and meaningful use initiatives will require systems to demonstrate (in a standardized manner) how a patient's care resulted in positive outcomes and high quality "patient experience of care," required for federal reimbursement/payment.³⁹ This shift in the federal reimbursement structure will require detailed clinical documentation of patient care processes, outcomes, and patient experience of care. Nurses provide the majority of patient care and are the provider most frequently seen by patients. Therefore, performance-based payment incentives increase the importance of nursing. Increasing the information related to nursing care in HT clinical documentation will enable nurse-employers to recognize the monetary value of nursing care and the influence of nursing care on patient outcomes.⁴⁰

Many medical errors are intercepted because of nursing attention to and observation of patients. Medication errors, hospital "never events," and physician and nursing errors are averted because of nursing knowledge, alertness, and interaction with patients. Nurses develop an in-depth knowledge of each patient's current health condition, health history, and personal background. Nursing education includes studying the relationship among the patient's health, social circumstances, and psychological condition and how this impacts the patient's response to medical treatment.⁴¹ Comforting patients to relieve stress and ease their worries often results in improved patient outcomes. This increases patient satisfaction scores, which directly impacts federal reimbursement.⁴² Documentation of nursing clinical observations and nurse-patient interaction is necessary to demonstrate how improved outcomes and patient satisfaction scores are achieved.⁴³ At present, not all HIT systems incorporate standardized nursing clinical codes permitting this information to be transformed into clinical data.⁴⁴ Impending federal "meaningful use" requirements will require nurse employers to record patient outcomes in a standardized manner, a step which has been shown to increase the quality of patient care.⁴⁵

Standardized records in EHR systems show the benefits and correlations among appropriate nursing care, coordination of care, reduced readmission rates, and increased patient use of preventative healthcare. Utilizing EHR systems, HealthPlus of Michigan identified patients not filling their prescribed hypertension medications and notified the patients' healthcare providers of patient noncompliance; this led providers to work with patients to improve medication compliance, which contributed to reducing patients' high blood pressure by 27 percent.⁴⁶ Although the health plan experienced increased costs because patients were taking their medications, the health plan expected to see future cost reductions due to the preventative measures the EHRs provided.

The Medicare hospital-acquired-conditions policy is an example of a quality assurance program now integrated into pay-for-performance reimbursement systems. Nursing is critically important in reaching quality assurance goals and in documenting the steps taken to improve quality assurance processes.

Recommendation 8d - Telehealth Technologies

To improve access to safe, quality healthcare for Michigan residents, nurse-employers must integrate Telehealth technologies into their care settings and practices.⁴⁷

Reasons for Recommendation 8d - Michigan's rural and underserved communities continue to have difficulty in recruiting and maintaining the presence of primary care and specialists healthcare providers. Telehealth services maintain quality care outcomes, while allowing those in rural or underserved communities the opportunity to see providers and specialist providers in a more accessible manner.^{48 49}

When providers utilize healthcare technology (including Telehealth care), consumers are enabled to submit data, ask questions, and communicate with their healthcare provider establishing an interactive healthcare experience. An electronic intensive care unit (eICU) launched in Providence Hospitals increases access to intensive care units to rural and underserved hospitals. By increasing access to ICUs, rural hospitals and patients incur reduced hospital and transportation costs⁵⁰ for patients and procedures. The eICU program provides electronic monitoring of ICU patients, access to additional skilled bedside nurses and physicians, and guidance on lifesaving procedures, saving patient lives and healthcare costs.⁵¹ Decreased hospital readmission rates occur when individuals have the opportunity to see specialists and primary care providers on a consistent basis, and Telehealth services allow patients in rural and underserved communities this opportunity at lower costs.^{52 53}

Telehealth technologies allow patients to receive telemedicine on a consistent basis and maintain a relationship with their primary care providers and healthcare specialists.⁵⁴ Data from the Upper Peninsula Telehealth Network, Marquette General Hospital, and Wayne State University College of Nursing concluded that 87% of patients agreed that Telemedicine technologies saved time and 76% of patients agreed that telemedical care received was as good as face-to-face (patient and provider) care received.⁵⁵ The study also concluded that without telemedicine technologies, 44% of patients would have elected to not see their provider at all.⁵⁶ With a nationally recognized physician shortage,⁵⁷ telemedicine technology provides an opportunity for providers to geographically expand their practice without decreasing quality.

Telehealth network rural diabetes patients have increased access to diabetes care with Telehealth technology, and have shown improvements when completing and submitting consistent Telehealth reports from home to their primary care provider. Telehealth home reporting allows primary care providers the ability to monitor the treatment of several patients without requiring them to travel considerable distances.^{58 59} The United States Veterans Affairs Clinics (VA) are viewed as champions in Telehealth services.⁶⁰ Once viewed as, “second-rate care or worse” VA Hospitals are now leaders in efficiency and quality due to their inclusion of technology into patient care.⁶¹ VA Programs such as “VTell,” and “Health Buddy” (a home-based care program) that focuses on increasing relationships between patients and providers, have increased access to care for American’s veterans and have been proven to reduce hospitalizations by allowing veterans’ healthcare and treatments to be managed on a consistent basis. Telehealth and other technology programs have contained per patient costs for the VA, while the average healthcare costs continue to increase dramatically.^{62 63 64} Secretary of Veterans Affairs, Dr. James B. Peake described Telehealth services as, “making health care more effective because it improves patients’ access to care and is easy to use. Patients in rural areas are increasingly finding that Telehealth improves their access to health care and promotes their ongoing relationship with our health care system.”⁶⁵

Studies such as the Robert Wood Johnson Foundation funded Project ECHO, have shown greater patient access to healthcare specialists and primary care providers occurs when patients are involved in a Telehealth network. Management of Hepatitis C in a Telehealth delivery model showed improved patient outcomes resulting from primary care providers’ management of patients’ multiple chronic conditions in consultation with specialist providers. Both patients and providers must also learn to use and be comfortable using telehealth technology and devices. This requires patience and persistent effort, but the benefits are worth that effort.⁶⁶ With experience, both providers and patients recognize that outcomes improve and the patient-provider relationship is more effective.⁶⁷

State legislation, based on model legislation from the National Council of State Boards of Nursing (NCSBN), has enabled RNs in 24 states to participate in the Nurse Licensure Compact (NLC). The NCSBN provides the framework and conditions of participation for the NLC. Nurses licensed in NLC states are accessible to patients in an expanded geographical area (all NLC states) The NLC allows nurses to practice physically and electronically across state lines; increasing patients’ access to care.⁶⁸ “Telephonic” case management, care management, triage care, and health coaching, occur more efficiently when patients are able to quickly contact a licensed provider. Michigan’s rural resident’s

access to care increases as more RNs are available to provide Telehealth services, while maintaining safety and quality care standards.

Patients with multiple chronic conditions require consistent follow up and monitoring by healthcare providers. Telehealth technologies allow providers to have full access to their patients to monitor their conditions before more drastic treatments are needed.⁶⁹ *The Institute of Medicine* recommended in its, “Retooling for an Ageing America” report that more systems must be developed to engage persons with chronic conditions to become active participants in their health care. Telehealth services, including monitoring technologies, require geriatric patients to be actively engaged and increase communication between the entire care team.^{70 71} According to a study conducted by the Consumer Electronics Association, 36% of consumers are interested in consulting with their provider via wireless devices, and 32% of consumers are interested in consulting with their providers via online video.⁷² Engaging the public to be active partners in their health care increases patients’ overall health because of increased patient-provider communication. “Health Information Technologies and remote monitoring technologies improve communication among all caregivers and enable health professionals to be more efficient.”⁷³

Under the ACA, in 2013 Medicare will begin penalizing hospitals with high readmission rates. Currently, one in three Medicare patients is readmitted to a hospital within one month of discharge, leading to unnecessary healthcare spending totaling \$29 billion in 2009.⁷⁴ Telehealth and monitoring technology systems enable providers to monitor the vital signs of patients before symptoms become medical emergencies requiring hospitalizations.^{75 76} When using patient monitoring systems, Priority Health saw a 34.7 percent reduction in ER and inpatient costs for Medicare Advantage patients with heart failure.⁷⁷ Additional studies have also concluded that readmission rates for cardiovascular heart failure patients,⁷⁸ stroke, diabetes, and mental health patients have decreased when Telehealth and electronic monitoring technologies are used. These technologies help patients and providers, as well protecting hospital revenue by reducing readmission rates.

Simulation Technology - provides healthcare students and practitioners with learning experiences that simulate real-life healthcare situations; treatments and procedures may be practiced, clinical decision-making and skills may be improved, and situational protocols and interactions may be developed and tested. Simulations may range from single-skill mannequins (ex: a simulated human arm on which to practice IV insertions), to role-playing exercises that improve cultural competency, and communications with patients and care team members, to highly realistic mannequins programmed to present complex healthcare situations, to web-based environments (healthcare gaming) that simulate care settings, patients, and other providers. Simulations provide useful clinical experiences while maintaining patient safety.⁷⁹

Recommendation 8e - Simulation Technologies

To improve access to safe, quality healthcare for Michigan residents, nursing employers and educators must integrate simulation technologies into their curricula and practices. Guidelines, assessments, and tools must be developed to standardize simulation technology practice and adoption in all care settings, which cover the extent to which simulations may be substituted for required clinical experiences and Continuing Education credits.⁸⁰ Professional and education associations must develop guidelines, assessments, and tools to standardize simulation technology practice and adoption in all care settings.

Reasons for Recommendation 8e - As the population ages, Michigan healthcare providers will be responsible for caring for an increased elderly population with multiple chronic diseases.⁸¹ To better educate patients and providers to manage multiple chronic conditions, simulation technologies must be integrated into nursing education and practice. Patients and providers also experience decreased stress levels knowing clinical students have experienced similar situations in simulated exercises. Management of multiple chronic conditions requires both flexibility and in-depth knowledge, as chronic conditions interact with one another and with the patient’s unique health status; the nursing profession must utilize all resources to maintain an excellent professional knowledge base while maintaining patient safety.

Simulation technology ensures patient safety while permitting students and practicing nurses to acquire and improve clinical competencies, experience, and knowledge on a range of conditions.⁸² Simulation technology adds a dimension to medical and surgical studies for nursing students and provides practicing nurses the ability to expand their practice competencies in a safe environment. The *Simulation Technology & Innovation in Michigan Nursing Education Report*, completed in collaboration with the Michigan Department of Community Health-Office of the Chief Nurse Executive and Michigan Public Health Institute, shows that simulation technology enables nursing students to practice their nursing skills in simulated environments. The report showed strengthened students clinical, teamwork, and communication skills in environments that ensured patient safety. A simulation environment allows instructors to replicate varying clinical situations so students and practicing nurses can have hands-on clinical practice, while learning at their own pace. As a result, patients receive improved quality of care as increased confidence levels, critical thinking skills, cultural competency, and teamwork skills are applied in real-world clinical practice.⁸³ Incorporating simulation education technology into nursing education and practice settings provides an efficient and effective way to use scarce nursing educational resources.

Considering that we are at the beginning of a national healthcare provider shortage, simulations and Telehealth technologies will be needed to meet demand.⁸⁴ Simulation education technologies can assist in preparing nurses and nursing students to provide healthcare services in Telehealth networks. Patients in rural and underserved communities who utilize Telehealth and simulation technology will receive increased access to healthcare providers and specialists; in addition, providers and patients experience increased patient interaction and involvement in their personal healthcare plan.

Please see Appendix B, Case Statement III for the TFNP framework for integrating simulation resources into nursing education and practice.

Who Will Benefit from the Recommended Solution?

Implementation of the Recommendation will increase the efficiency and effectiveness of Healthcare Technology (HT) and Health Information Technology (HIT) as tools to be employed in nursing practice:

This will benefit persons who receive healthcare in Michigan, since HT will increase communication between patients and healthcare providers. Healthcare consumers have an increasing interest in communicating with their healthcare providers via wireless devices in order to maintain the patient's health and wellness.⁸⁵ HT and Telehealth devices increase communication between patients and providers and also improve collaboration between providers through mobile health care applications and devices.⁸⁶ Nursing continues to be the most trusted health profession⁸⁷ and has a long history of patient advocacy. Nursing involvement in HT systems will increase advocacy for patients and for patient involvement in their personal health. In turn, patients will have their own health data and, "will be more likely to ask the right questions, make better decisions and receive better care."^{88 89}

This will benefit persons who receive healthcare in Michigan, since HT will increase the resources available to healthcare providers. Rural and underserved communities will benefit from Telehealth technologies that decrease care costs through reducing hospital admission and readmission rates, while increasing access to primary care and specialty providers.⁹⁰

This will benefit persons who receive healthcare in Michigan, since HT will increase efficiencies in nursing communication, workflow, and patient care. With increased numbers of nurses using mobile devices for personal communications,⁹¹ software companies have developed HIPAA-compliant applications (also-known-as "apps") that assist in patient care delivery, patient health education, communications between members of the patient care team,⁹² and offer additional access to patient records.⁹³ Evidence-based best practices (organized in the Cochrane data bases) are available for nurses to utilize on smartphones and tablets; this improves nursing assessments of patients and assists in providing best care practices for all patients.^{94 95 96} These mobile applications also provide information on drug

interactions, appropriate medication dosing, retail pricing of medications, adverse medication interactions, Medicare Part D, pharmacology, and safety monitoring assistance to nurses,^{97 98} which save nursing time and increase the efficiency and quality of care provided.⁹⁹ HT communication devices also improve nurse response time to patient calls.¹⁰⁰ Additionally, wireless communication technologies and real-time location tracking systems have been shown to increase nursing care efficiencies, by limiting time spent searching for equipment/supplies and other members of the care team.¹⁰¹

Telehealth technologies will benefit persons with little access to healthcare specialists. For example, Munson Medical Center (Traverse City) uses collaborative Telehealth programs to connect the Munson neonatal unit with neonatal specialists at The University of Michigan Health Center (Ann Arbor) and pediatric specialists at Devos Children's Hospital (Grand Rapids). These services permit patients in more rural areas to benefit from connectivity to top area specialists.

This will benefit healthcare providers in Michigan, since HT will decrease wasteful spending on practice inefficiencies. The annual economic burden of poor communication and care coordination results in an average annual loss of \$4 million for a 500-bed acute care hospital.¹⁰² Thirty-six percent of that economic burden is due to wasted nursing time. By including experienced direct care RNs and RN leaders in all areas of HT design, development, implementation, and evaluation, healthcare systems will improve communication and care coordination, resulting in savings.¹⁰³

This will benefit persons who receive healthcare in Michigan, since HT such as EHRs have been proven to improve positive outcomes for patients, compared to paper records.¹⁰⁴ EHRs provide real time patient information to providers, improving coordination of care and care outcomes.^{105 106 107 108} Several studies have concluded that utilization of EHR in conjunction with clinical care has improved outcomes for diabetic and cardiovascular patients.¹⁰⁹ American taxpayers and the healthcare industry will benefit from increased utilization of EHRs.¹¹⁰ For example; in 2010 the economic cost of obesity reached \$300 billion, according to a study released by the Society of Actuaries.¹¹¹ Utilization of EHRs will permit primary care providers to counsel their patients, monitor their health, providing timely recommendations; ultimately reducing healthcare spending.¹¹²

This Recommendation and Position Paper is consistent with Governor Snyder's Michigan 3.0 Vision and the Michigan Department of Community Health Strategic Priorities. Governor Snyder has addressed the need to increase utilization of healthcare technology to increase efficiency and access to care in Michigan. The Task Force on Nursing Practice agrees that health care technology can increase access to care, permitting more Michigan residents to receive safe high quality care, at lower cost.¹¹³

Background: Michigan's strategic plan for addressing the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP is composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met for the first time in December 2010 and continues through April 2012 to gather information, consult with state and national experts in nursing practice and policy, and consider issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Advancing Technology in Nursing Practice and Health has been determined by the TFNP to be of high priority.

Appendix A – Recommended Definitions

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Care across the lifespan - The care of an individual from pre-natal care to death.

Electronic Health Record (EHR) - Computer software used to record/capture and store information about patient health history, conditions, treatment, outcomes, and providers.

Healthcare Technologies (HT) - *Tools that assist patient care. HT includes, but is not limited to: electronic devices that assist in patient care, electronic teaching tools, electronic monitoring systems and devices, and electronic health records, etc. Technology impacts patient care received and must support the standards of practice in all practice settings. Health Information Technology (HIT) is a tool that allows information to be accessed independently, regardless of patient or provider location, allowing individuals to communicate to benefit patient care and outcomes.*

“Meaningful Use” of Electronic Health Records¹¹⁴ - The federal definition of Meaningful Use is being rolled out in 3 stages. Stages 1 & 2 have been defined, while the remaining stage will be completed by 2015. For more detailed information on the requirements for Meaningful Use Stages 1 & 2 please see www.healthit.hhs.gov. The main components of Meaningful Use are: the use of a certified EHR in a meaningful manner, such as e-prescribing, the use of certified EHR technology for electronic exchange of health information to improve quality of health care, and the use of certified EHR technology to submit clinical quality and other measures.¹¹⁵ The definition of Meaningful Use has been updated several times and is best accessed through the federal website:

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2> and/or http://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp.¹¹⁶ [As of April 1, 2012]

Nurse - *When used without modification or amplification, means only a registered nurse.*¹¹⁷

Patient-centered care - Care that puts the needs of the patient first.

Performance based incentives - Are usually monetary rewards for meeting performance standards set by the entities providing payment for services received. Health insurance companies, for example, may offer incentives for providing healthcare more efficiently, or for following “best-practices” in healthcare. The federal Centers for Medicare and Medicaid Services (CMS) and DHHS-Health Resources and Services Administration (HRSA) have several programs in which payment for healthcare services is tied to meeting performance standards for quality and safety in the provision of healthcare.

Practice of nursing - *The systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition.*^{118 119} *Nursing is a profession that is evidence-based, and requires an understanding of the human condition and applies the current science of professional caring¹²⁰ to health goals mutually established with patients goals.*¹²¹

Simulation Technology - Provides healthcare students and practitioners with learning experiences that simulate real-life healthcare situations; treatments and procedures may be practiced, clinical decision-making and skills may be improved and situational protocols and interactions may be developed and tested. Simulations may range from single-skill mannequins (ex: a simulated human arm on which to practice IV insertions), to role-playing exercises that improve cultural competency, and communications with patients and care team members, to highly realistic mannequins programmed to present complex healthcare situations, to web-based environments (healthcare gaming) that simulate care settings, patients, and other providers. Simulations provide useful clinical experiences while maintaining patient safety.¹²²

Telehealth - *The use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, monitoring devices, and terrestrial and wireless communications.*¹²³

Appendix B – Case Statements

Case Statement I – Implementation of Electronic Health Records

- a. In the future, the provision of high quality, safe healthcare to patients will be dependent upon the integration of technology into practice in ways that potentiate and transform care. Technology should supplement the clinical judgment of healthcare professionals, not replace that judgment.¹²⁴
- b. Registered Nurses (RNs) must take a strong role in the delineation of healthcare information systems and the implementation of those systems into practice. Healthcare information systems must be developed in a manner that supports the evolved role of nursing and the evolved role of patients as members of healthcare teams.
- c. Implementation of the Patient Protection & Affordable Care Act is expected to provide positive conditions for the creation of multiple Accountable Care Organizations (ACOs); the definition of an ACO awaits the promulgation of regulations from DHHS, but current examples are largely vertically integrated entities (i.e., including providers from community-based primary care to acute care) who assume capitated responsibility for the healthcare of a defined population. Electronic Health Records (EHRs) will be a major feature of ACOs, which need to document preventive health measures, care coordination, and efforts made to improve and maintain the health of their patients.
- d. Health Information Technology (HIT) is an emerging and major factor in the healthcare environment. Incentives were provided in the American Recovery and Reinvestment Act (ARRA) for physician practices and health provider institutions to invest in “meaningful use” of Electronic Health Records to make more efficient, safe use of patient health information. There are no incentives in place to support Advanced Practice Registered Nurses (APRNs) use of this technology; this lack of funding could further reduce access to care for vulnerable populations.
- e. The national and regional organizations setting up, writing specifications for, and implementing health information technologies and systems must recruit healthcare professionals (nurses, physicians, and allied health professionals) to participate in these activities. The potential of HIT systems at all levels to transform healthcare practice may be realized only when all healthcare professionals are engaged in planning and specification of systems from the beginning.
 - An interdisciplinary discussion of HIT should be initiated to deal with practice/HIT issues common to healthcare professions. Experience and training in the supportive use and integration into practice of HIT is needed across the spectrum of healthcare professions and practice settings.
 - Acceptance issues with respect to HIT and healthcare technology must also be addressed. There are positives/negatives in full acceptance and engagement in use of HIT, since some healthcare professionals may be reluctant to learn to use HIT, while others are immersed in it. The importance of HIT in healthcare quality and safety is extensively discussed in QSEN materials and in *Educating Nurses*.¹²⁵¹²⁶
- f. Nurses must have voice and take a strong role in the specification and integration of new healthcare technologies in healthcare provider systems.¹²⁷ HIT must support the standards of nursing practice and be integrated into nursing workflow to improve and maintain nursing care outcomes.
 - Consider the development of HIT nurses and their role as the intermediary between nursing and HIT. Reporting to the Chief Nurse Executive, HIT nurses would bring HIT systems knowledge blended with clinical practice experience to the clinical care area, and bring nursing informatics knowledge and clinical expertise to HIT systems. Improvement of the knowledge base of both nursing and IT specialists is reinforced by the American Hospital Association’s inclusion of EHR competency in their standards for hospital-based APRNs.¹²⁸
 - Consider the current difficulty of synchronizing nursing patient-care workflow and the requirements of hospital or practice record systems. Nurses must have flexibility to handle the

changing needs of patients. This means that it is not always possible to immediately post to a patient's computerized chart the nursing services provided, or to provide the service at the time preprogrammed into the charting computer. Current charting systems often are cumbersome, requiring multiple actions (log-ins, pull-down menus, etc.) to reach the specific field for data entry; the time to perform data entry may not be available until end of shift. Since chart entries are date/time stamped with the time they were entered, rather than the time the tasks were performed, it is not surprising that records may not be synchronized with a preprogrammed schedule. As EHRs take the place of current systems, documentation policies must be updated to reflect the new system. Nurses must be engaged and empowered at every stage of EHR selection and development, so that nursing care is supported and improved by EHR use, with no disruptions of workflow. Safe, high-quality patient care must always be the goal.

- Learn from the utilization of HIT in community-based hospice and home care operations. These care settings already are emerging as ones in which HIT and communications technology may play major and positive roles in nursing care.
- g. Ambulatory care settings and community care settings may provide appropriate venues to demonstrate the effective use and value of healthcare technologies and HIT. Healthcare technology already includes "Health buddy" systems for compiling health assessment information at a distance and transmitting it to a care coordination nurse for review and response. The Veterans Administration performs care coordination using such technology; an on-line nursing care coordination fee-based service recently went into operation in Minnesota¹²⁹. Nurses should support and participate in the development of initiatives to implement and test the applications of healthcare technology and HIT in community settings.
- h. All practice environments should utilize HIT data and EHR data to show the benefits of the nursing profession and practices on patient care outcomes. Implementation of HIT must be accompanied by rigorous adoption of standards of practice, derived from the standard of care that the technology is intended to support. For example, EHR data can support return on investment reports for nurse staffing and also support the development of new care best-practices.

Case Statement II – Health Information Technology System Infrastructure

1. **The Selection Committee** is required for appropriate selection of a Health Information Technology (HIT) product (software) and the hardware and HIT personnel required to efficiently and safely operate the HIT system. The Selection Committee should include representatives from all major professional groups [including Chief Nurse Executive and Chief Medical Officer] expected to use the HIT system, plus those expected to operate and maintain the system, and those expected to use information from the system to evaluate institutional and subgroup performance (healthcare outcomes, efficiency, quality, safety, and financial sustainability). This process usually includes requirements analysis (inputs and outputs), projections of future need, data security needs, expansion capacities, training needs, and costing for original software and hardware, customization, maintenance, and upgrades, as well as hiring and training of HIT staff and training of clinical staff. Comparative costing may also be done for outsourcing some or all of the components above. Once software and hardware selection is made, the Selection Committee reviews and recommends contracts for software and hardware, customization, maintenance, upgrades, and training (or outsourcing of same). [The following steps proceed in a sequence.]
2. **The Development Committee** sets up the workplan/timeline and outcomes criteria for HIT software and hardware system. The Development Committee should include major members of the Selection Committee, plus middle-level managers whose staff will be engaged in the development process. The Development Committee plans and authorizes facilities for customization programmers, servers to house pre-production software testing; selects in-house clinical units and professional groups to assist in testing at various stages of configuration before system “goes live.” Reviews and recommends contracts and modifications if necessary.
3. The Development Committee closely monitors the workplan/timeline, making modifications when necessary. Plans extensive testing and documentation of testing in real-world environments, recruits testers, sets criteria for outcomes; implements and enforces plan. System does not “go live” until all testing requirements are met, and deficiencies are appropriately remedied. Reviews and recommends contracts and modifications if necessary.
4. **The Governance Committee** is derived from the Selection Committee, Development Committee, and tester groups; the timeline for the Governance Committee overlaps that of the Selection Committee. Sets guidelines and rules for HIT system activation, utilization, management, and enhancement. Requires appropriate training in system utilization for all relevant staff and consultants; requires appropriate use of the HIT system by all designated categories of staff and consultants. Sets standards for use of current HIT system, criteria for enhancement and channels for submission of enhancement requests.
5. To ensure that the implementation timeline supports the care environment, the accountable person for care (usually the Chief Nurse Executive), in consultation with other members of the Governance Committee, decides when to implement the training program and when to activate the HIT system. The Committee oversees the coordination of necessary trainers, times, and facilities for training; training includes process for submitting HIT enhancement requests; thereafter, training content becomes staff competencies, validated annually or as defined by policy. Committee monitors changeover from previous information system, tracking system errors, programming errors, utilization errors, and the time required to remedy each. Reviews and recommends contracts and modifications if necessary.
6. As the HIT system settles into standard use patterns, the Governance Committee monitors the clinical user’s reported needs for enhancements and timeliness of response (for example, corrections needed to maintain patient safety are implemented immediately, while less urgent enhancements may wait until users have become competent and facile with the technology), level of utilization, training deficiencies and needs, costs, outcomes, and perceptions of clinical staff and HIT personnel. System evaluations are performed at quarterly intervals. Additional categories of users sit on Governance Committee to broaden engagement of clinical staff in future structural and functional changes for the HIT system. The Governance Committee is a permanent committee charged with optimizing the functioning and utilization of the HIT system. Inputs and outputs from the system are evaluated periodically and improvements are made. An automated training system is established as a part of the institutional communications system, with updates as the HIT system is upgraded.

Case Statement III – Integrating Simulation Resources into Nursing Education and Practice

The availability of simulation technology resources and the consistent use of simulation resources in Michigan nursing education programs and in nursing practice settings should be assessed and monitored by the Michigan Nursing Practice Council (see TFNP Recommendation 10).

To improve the consistency of simulation education systems in nursing education and practice, simulation resources must be uniformly available (from a library of such resources), and there must be guidelines for the use of simulation resources. The Michigan Nursing Practice Council (MNPC), in collaboration with the Michigan Nursing Education Council (MNEC), is the appropriate entity to develop guidelines and oversee the creation of a Simulation Resource Library (SRL).

The suggested architecture for the library is a distributed simulation library with a common framework and presentation format. Guidelines for use of SRL resources should specify content categories and appropriate access, management, and utilization procedures. The development of simulation technology scenarios is extremely time consuming and requires faculty development and education on simulation technology. To aid schools engaged in simulation technology, the SRL would allow education and practice faculty to share resources. SRL content must include the sharing of complex practice scenarios and continued education simulation courses, reinforcing nursing best-practices for practicing nurses.

For example, a major content category would be Registered Nursing, with content covering practice competencies all Registered Nurses (RNs) must have, plus one or more nursing specialties. The RN collection of simulation resources could be housed in a number of physical locations, but be electronically managed by any of the major nursing professional organizations (Michigan League for Nursing, for example). The Advanced Practice Registered Nurses (APRNs) collection could be electronically managed by a professional organization or coalition of professional organizations focused on advancing nursing practice and education in accordance with professional nursing practice guidelines.

Funding for the SRL could be arranged in a variety of ways: Subscription fees from educational and practice institutions utilizing the library are one possibility; a set-aside from the Nursing Licensure Funds is another. Foundation or federal grants may be needed to provide start-up funding.

The library could be planned and implemented in phases, with phase 1 developing the RN library of simulation resources, with a common framework and presentation format appropriate to RN practice. Phase 2 would add the APRN simulation technology resources, information about simulation technology in healthcare, and quality assurance standards appropriate to the practice of APRNs.

In addition to simulation resources, the library may also include general documents on the use of simulation in nursing education and practice, information on simulation projects and products (including those in use), facilities, links and references. The library contents would be assessed on a yearly basis to measure use and perceived effectiveness of each resource. This library collection would benefit everyone who receives healthcare in Michigan, since the utilization of simulation would be a part of the overall practice standard. The library would maintain not only a catalogue of simulation resources and information about simulation technology, it also would maintain a description of simulation assets in Michigan; this would require performing an inventory every year or two.

The MNPC and MNEC are urged to include the SRL among their priorities. At a time when nursing education faculty are increasingly scarce and clinical education sites for students are increasingly difficult to find, simulation technology offers useful and safe clinical experiences for nurses at all levels of education and practice, while maintaining patient safety. The SRL is a major step toward improving nursing education and practice quality across the state, with consistency and quality assurance.

End Notes

- ¹ US Census. 2010. Michigan Results.
- ² Fairman, J., J. Rowe, S. Hassmiller, & D. Shalala, (2011). Broadening the Scope of Nursing Practice. *The New England Journal of Medicine*. 364, 193-195.
- ³ Bielaszka-DuVernay, Christina. (2011). Improving Quality and Safety. *Health Affairs and Robert Wood Johnson Foundation*.
- ⁴ Governor Rick Snyder. *A Special Message from Governor Rick Snyder: Health and Wellness*. State of Michigan Executive Office. September 14, 2011.
- ⁵ Agarwal, Ritu, Daniel Sands, and Jorge Diaz-Schneider. Quantifying the Economic Impact of Communication Inefficiencies in US Hospitals. *Center for Health Information and Decision Systems*. Vol. 3 Issue 1B.
http://www.rhsmith.umd.edu/chids/pdfs_docs/ResearchBriefings/CHIDS-ResearchBriefing-Vol3Issue1a.pdf
- ⁶ Nurse, when used without modification or amplification, means only a registered nurse licensed under this article to engage in the practice of nursing.
- ⁷ U.S. Department of Health and Human Services, Agency for Healthcare Research Quality. Toolkit: Health Information Technology Implementation Workflow. Retrieved from
http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_0_8605_919_0_43/withitoolkit/faces/withitMain.jsp;jsessionid=C64ABA91B5C5C7D01C3AA7133144C09C
- ⁸ Nursing Practice Issue Forms submitted to the Michigan Department of Community Health- Task Force on Nursing Practice. December 2010-April 2011.
- ⁹ American Nurses Association . (2010). *Nursing's Social Policy Statement*.
- ¹⁰ Kurtzman, Ellen. (2011). Performance-Based Payment Incentives Increase Burden and Blame for Hospital Nurses. *Health Affairs*. Feb. 2011 30.2
- ¹¹ Turisco, Fran, Rhoads, Jared. (2008). Equipped for Efficiency: Improving Nursing Care Through Technology. *California Healthcare Foundation*.
- ¹² *Care across the lifespan* refers to the care of an individual from pre-natal care to death.
- ¹³ Kutney-Lee, A., D. Kelly. (2011). The Effect of Hospital Electronic Health Record Adoption on Nurse-Assessed Quality of Care and Patient Safety. *Journal of Nursing Administration*. Volume 41, Nom. 11. 466-472.
- ¹⁴ Department of Health and Human Services, American Recovery and Reinvestment Act. Health Information Technology. Office of the National Coordinator for Health Information Technology: Health Information Technology.
<http://www.hhs.gov/recovery/reports/plans/pdf20100610/ONC%20HIT%20June%202010.pdf>
- ¹⁵ Cartwright-Smith, Lara, Hyatt Thorpe, Jane, and Rosenbaum, Sara. (2011). Easing the Pathway to Accountable Care Organizations: Final Administration Policy.” The Bureau of National Affairs.
- ¹⁶ Dennehy, Patricia; White, Mary; Hamilton, Andrew; Pohl, Joanne ; et al. (2011). A Partnership model for Implementing Electronic Health Records in Resource-Limited Primary Care Settings: Experiences from Two Nurse-Managed Health Centers. *Journal of American Medical Informatics Association*.
- ¹⁷ The engagement of nurses in the decision-making and actions surrounding HT purchase and implementation should ensure that HT systems collect and provide information relevant to nursing care of patients. This means that nursing care definitions and algorithms that relate to nursing patient care must be included in the structures and information collection capacities of HIT and HT systems, all of which must be safe for nurses to use in patient care, and compatible (i.e., able to share information with one another). This will ensure that HT and HIT systems support nursing assessment of patients, patient care, and nursing care workflow. Since patient outcomes and patient experience of care are included in the federal evaluation of care quality, which will determine federal reimbursement/payment levels, there should be strong institutional motivation for nursing engagement in decision-making.
- ¹⁸ Shifting Federal reimbursement structure to pay per performance.
- ¹⁹ Mosquera, Mary. (2011). Despite ACO rule, EHRs still key to clinical decisions. *Government Health IT*.
- ²⁰ Agarwal, Ritu, Daniel Sands, and Jorge Diaz-Schneider. Quantifying the Economic Impact of Communication Inefficiencies in US Hospitals. *Center for Health Information and Decision Systems*. Vol. 3 Issue 1B.
http://www.rhsmith.umd.edu/chids/pdfs_docs/ResearchBriefings/CHIDS-ResearchBriefing-Vol3Issue1a.pdf
- ²¹ Douglas, Kathy. (2011). What Every Nurse Executive Should Know about Staffing and Scheduling Technology Initiatives. *Journal of Nursing Economics*. September-October Vol. 29. No. 5.
- ²² Kurtzman *op cit*.
- ²³ “Survey results demonstrate improved nurse job satisfaction.” *Alberta RN* 2005; 61 (6): 14.
- ²⁴ American Nurses Association. (2005). Survey of 76,000 nurses probes elements of job satisfaction. *NursingWorld*.

-
- ²⁵ Natale, Patricia. Personal communication, November 2011.
- ²⁶ HT systems require investment in physical infrastructure and management infrastructure. Requiring appropriate staffing, governance structure, committees, policies and procedures to maintain, upgrade, regulate, and evaluate the technology.
- ²⁷ Douglas *op cit*.
- ²⁸ Dennehy, P., M. White, A. Hamilton, J. Pohl, et al. (2011). A Partnership model for Implementing Electronic Health Records in Resource-Limited Primary Care Settings: Experiences from Two Nurse-Managed Health Centers. *Journal of American Medical Informatics Association*.
- ²⁹ *Ibid*.
- ³⁰ Personal statements recorded at the TFNP Regional Forums. June-October 2011.
- ³¹ Agarwal, Ritu, Daniel Sands, and Jorge Diaz-Schneider. Quantifying the Economic Impact of Communication Inefficiencies in US Hospitals. *Center for Health Information and Decision Systems*. Vol. 3 Issue 1B.
http://www.rhsmith.umd.edu/chids/pdfs_docs/ResearchBriefings/CHIDS-ResearchBriefing-Vol3Issue1a.pdf
- ³² American Nurses Association (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition.
- ³³ Some Michigan hospitals have developed HIT nurses and placed them in HIT departments as the voice of nursing in IT/EHR development and implementation; such HIT nurses serve as the interface between IT specialists and nursing clinical departments.
- ³⁴ Turisco, Fran, Rhoads, Jared. (2008). Equipped for Efficiency: Improving Nursing Care Through Technology. *California Healthcare Foundation*.
- ³⁵ Burnes Bolton, Linda, Gassert Carole A., and Cipriano, Pamela F. (2008). Smart Technology, Enduring Solutions, Technology Solutions Can Make Nursing Care Safer and More Efficient. *Journal of Healthcare Information Management*. Volume 22, No. 4.
- ³⁶ U.S. Department of Veterans Affairs. (2009). *VA Data Show Home Health Technology Improves Access to Care. Peake: Entire Health Care System More Effective*. January 5. <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1637>
- ³⁷ Smaller healthcare providers: critical access hospitals, rural hospitals, clinics, home health agencies, long-term care facilities, primary care providers, and smaller hospital and provider practices.
- ³⁸ In the information technology realm, the term “captured” is used to refer to recorded data or information.
- ³⁹ CMS Final Rule Requirements
- ⁴⁰ Keepnews, David. (2011). Mapping the Economic Value of Nursing: A White Paper, Seattle: Washington State Nurses Association.
- ⁴¹ Watson, Jean. (2008). *Nursing: The Philosophy and Science of Caring*. University Press of Colorado.
- ⁴² Under the upcoming pay for performance federal reimbursement structure
- ⁴³ Nursing care received by patients directly impacts patient’s satisfaction scores.
- ⁴⁴ ICD 10 and ICD-10 Procedure Coding System may provide additional nursing coding options
- ⁴⁵ Lindenauer RK, Remus D, Roman S, Rothberg MB, Benjamin EM, MA A, et al. (2007). Public Reporting and Pay for Performance in Hospitals quality improvement. *The New England Journal of Medicine*. 356 (5): 486-96.
<http://www.nejm.org/doi/full/10.1056/NEJMs064964>
- ⁴⁶ Greene, Jay. (2011). HealthPlus uses EMRs to track hypertension. *Crain’s Detroit Business*.
- ⁴⁷ Legislation is currently being reviewed by the Michigan State Legislature requiring reimbursement for Telehealth services. House Bill 5408 and House Bill 5421 can be viewed at www.legislature.mi.gov. Michigan’s Medicaid program currently reimburses for Telehealth services.
- ⁴⁸ Robert Wood Johnson Foundation. *Project ECHO*.
- ⁴⁹ Arora, Sanjeev; Thorton, Karla; Murata, Glen et al. (2011). Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers. *The New England Journal of Medicine*.
- ⁵⁰ Patients monitored by the eICU are removed from ventilators earlier than patients not involved in electronic monitoring. When patients at rural hospitals are unable to be stabilized they are often transferred to neighboring ICU’s, when eICU’s are in place transporting costs as eICU nurses and physicians are able to guide participating bedside nurses through lifesaving procedures.
- ⁵¹ Feidt, Annie. (2012). Electronic Intensive Care Unit Expands in Alaska. *Alaska Public Radio Network*.
- ⁵² Otto, Alexander. (2011). ED Telepsychiatry Cuts Admissions, Saves Money at South Carolina Hospitals. *Internal Medicine News*.

-
- ⁵³ Arora, Sanjeev; Thorton, Karla; Murata, Glen et al. (2011). Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers. *The New England Journal of Medicine*.
- ⁵⁴ Freeman, Liz. (2011). Devises Help Lee Memorial Monitor Vital Signs of Discharged Cardiac Patients. *Naples Daily News*.
- ⁵⁵ Makela, Susan; Manty, Joann; Buis, Lorraine. (2011). Telehealth: Creating Office Efficiencies-Myth or Reality. *Upper Peninsula Telehealth Network Michigan, Marquette General Hospital, Wayne State University College of Nursing*.
- ⁵⁶ *Ibid*.
- ⁵⁷ Governor Rick Snyder. *A Special Message from Governor Rick Snyder: Health and Wellness*. State of Michigan Executive Office. September 14, 2011.
- ⁵⁸ Bielaszka-DuVernay, Christina. (2011). Improving Quality and Safety. *Health Affairs and Robert Wood Johnson Foundation*.
- ⁵⁹ Orlovsky, Christina. (2011). Public Health's Take on Technology. *NurseZone*.
- ⁶⁰ Personal communications with members of the Task Force on Nursing Practice. December 2011-April 2012.
- ⁶¹ Stires, David. (2006). Technology has Transformed the VA. *CNN Money*.
http://money.cnn.com/magazines/fortune/fortune_archive/2006/05/15/8376846/
- ⁶² Stires, D. *op cit*.
- ⁶³ Department of Veterans Affairs, *op cit*.
- ⁶⁴ The Health Buddy system is based on proven technology that drives sustainable behavior change. An ongoing study comparing Health Buddy system users to a control group saw an 85% daily utilization rate, resulting in a 40% drop in acute hospital days, 68% fewer nursing home days and a 3.75% overall net reduction in medical costs for the Health Buddy group. http://www.bosch-telehealth.com/content/language1/html/5763_ENU_XHTML.aspx
- ⁶⁵ Department of Veterans Affairs, *op cit*.
- ⁶⁶ Stires, D., *op cit*.
- ⁶⁷ Arora, Sanjeev; Thorton, Karla; Murata, Glen et al. (2011). Outcomes of Treatment for Hepatitis C Virus Infection by Primary Care Providers. *The New England Journal of Medicine*.
- ⁶⁸ Nurse Licensure Compact Administrators. Fact Sheet: Nurse Licensure Compact. *National Council of State Boards of Nursing*. Retrieved from <https://www.ncsbn.org/nlc.htm>
- ⁶⁹ Kevin, Lasser. (2011). Telemedicine-Past, Present, Future" *Presentation at PNC Healthcare Symposium*.
- ⁷⁰ The Institute of Medicine. (2008). *Retooling for an Aging America: Building the Healthcare Workforce*.
- ⁷¹ Freeman, L., *op cit*.
- ⁷² Lerro, Colleen. (2011). CEA Study Finds Wireless Health Tech in Demand. *Consumer Electronics Association*.
- ⁷³ The Institute of Medicine. (2008). *Retooling for an Aging America: Building the Healthcare Workforce*.
- ⁷⁴ U.S. Department of Health and Human Services. (2011). *Administration Implements New Health Reform Provision to Improve Care Quality, Lower Costs*. April 29. retrieved from <http://www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011a.html>
- ⁷⁵ Marcy, Jessica. (2011). Home Health Advocates Push Remote Monitoring in Medicare. *Kaiser Health News*. Retrieved from <http://capsules.kaiserhealthnews.org/index.php/2011/12/home-health-advocates-push-remote-monitoring-in-medicare/>
- ⁷⁶ Gandey, Allison. (2011). Telestroke Cost-Effective in Improving Rural Care. *MedScape*.
- ⁷⁷ Cooley, Mary. (2011). Remote Patient Monitoring Cuts Costs. *Crain's Detroit Business*.
- ⁷⁸ Inglis SC, Clark RA, McAlister FA, et al. (2010). Structured Telephone Support or Telemonitoring Programs for Patients with Chronic Heart Failure. *Cochrane Database of Systematic Reviews*. Issue 8.
- ⁷⁹ For more information on simulation technologies and their use, see *Final Report: Simulation Survey of Michigan Nursing Education Programs, 2010-2011*, available at www.micnwp.org.
- ⁸⁰ National Council of State Boards of Nursing. *National Simulation Study*. Retrieved from <https://www.ncsbn.org/2094.htm>
- ⁸¹ Fairman, J. J. Rowe, S. Hassmiller, and D. Shalala. (2011). Broadening the Scope of Nursing Practice. *New England Journal of Medicine*. 364, 193-195.
- ⁸² For more information on simulation technologies and their use, see *Final Report: Simulation Survey of Michigan Nursing Education Programs, 2010-2011*, available at www.micnwp.org.
- ⁸³ *Ibid*.
- ⁸⁴ Wilemon, T. (2011). Vanderbilt nurses train in virtual world. *The Tennessean*. Retrieved from <http://www.tennessean.com/article/20110321/NEWS07/103210313/Vanderbilt-nurses-train-virtual-world>.

- ⁸⁵ Consumer Electronics Association. (2011). *CEA Study Finds Wireless Health Tech in Demand*. October 24. Retrieved from http://www.ce.org/Press/CurrentNews/press_release_detail.asp?id=12186
- ⁸⁶ Dolan, Brian. (2011). Kaiser Permanente Offers Patients Android App for EMR Access. *Kaiser Permanente*. Retrieved from <http://mobihealthnews.com/16047/kaiser-permanente-offers-patients-android-app-for-emr-access/#comments>
- ⁸⁷ Jones, Jeffrey. (2011). Ratings of Nurses, Pharmacists, and Medical Doctors Most Positive. *Gallup Poll*. Retrieved from <http://www.gallup.com/poll/151460/Record-Rate-Honesty-Ethics-Members-Congress-Low.aspx>
- ⁸⁸ Secretary Kathleen Sebelius, Department of Health and Health Services.
- ⁸⁹ Murphy, Judy. (2011). Engaging Patients and Families in eHealth. *The Journal of Nursing Economics*. Vol 29, No. 6.
- ⁹⁰ Otto, A. *op cit*.
- ⁹¹ Burnes-Bolton, Linda, Gassert Carole A., and Cipriano, Pamela F. (2008). Smart Technology, Enduring Solutions, Technology Solutions Can Make Nursing Care Safer and More Efficient. *Journal of Healthcare Information Management*. Volume 22, No. 4.
- ⁹² Horowitz, Brian. (2012). Avaya Demonstrates Health Care Messaging App for iPhone, iPad. *Eweek*. Retrieved from <http://www.eweek.com/c/a/Health-Care-IT/Avaya-Demonstrates-Health-Care-Messaging-App-for-iPhone-iPad-890136/>
- ⁹³ Gullo, Chris. (2011). Top 10 iPhone Medical Apps for 2011. *Mobile Health News*. Retrieved from <http://mobihealthnews.com/15229/top-10-iphone-medical-apps-for-2011/15/>
- ⁹⁴ *MassDevice*. (2011). Heart Education iPad app a First for Boston Scientific. Retrieved from <http://www.massdevice.com/news/heart-education-ipad-app-first-boston-scientific>
- ⁹⁵ Mularella, Josh. ERres iPhone and iPad application. <http://itunes.apple.com/us/app/erres/id413192645?mt=8>
- ⁹⁶ Weixel, Nathaniel. Elfin, Dana. (2012). FDA Expected in 2012 to Address Role in Regulating Software Applications. *Health IT Law & Industry Report*.
- ⁹⁷ Wirkus, Melissa. (2012). New Time-Saving Devices and Apps for Nurses. *NurseZone*. Retrieved from http://www.nursezone.com/Nursing-News-Events/more-news/New-Time-Saving-Devices-and-Apps-for-Nurses_38924.aspx
- ⁹⁸ Epocrates, Inc. *Mobile Products*. <http://www.epocrates.com/mobile>
- ⁹⁹ Companies such as Epocrates and Skyscape offer healthcare professionals and students access to clinical and drug references, education and training materials, medication guides, and many other practice based resources through mobile and tablet device applications. <http://www.skyscape.com/estore/productoverview.aspx> <http://www.epocrates.com/mobile>
- ¹⁰⁰ Turisco, Fran, Rhoads, Jared. (2008). Equipped for Efficiency: Improving Nursing Care Through Technology. *California Healthcare Foundation*.
- ¹⁰¹ Wireless communication technologies and real-time location tracking systems directly impact nursing workflow and therefore must be developed with the input of direct care nurses and nursing leadership. If HT systems are developed and implemented correctly, they can reach their maximum potential in improving nursing care efficiencies.
- ¹⁰² Agarwal, Ritu, Daniel Sands, and Jorge Diaz-Schneider. Quantifying the Economic Impact of Communication Inefficiencies in US Hospitals. *Center for Health Information and Decision Systems*. Vol. 3 Issue 1B. http://www.rhsmith.umd.edu/chids/pdfs_docs/ResearchBriefings/CHIDS-ResearchBriefing-Vol3Issue1a.pdf
- ¹⁰³ *Ibid*.
- ¹⁰⁴ Cebul, Randall, Love, Thomas, Jain, Anil, and Herbert, Christopher. (2011). Electronic Health Records and Quality of Diabetes Care. *The New England Journal of Medicine*.
- ¹⁰⁵ McNickle, Michelle. (2011). 5 Reasons EHRs Need to Grow Up.” *Healthcare Information and Management Systems*. Retrieved from <http://healthcareitnews.com/news/5-reasons-why-ehrs-need-grow-up>
- ¹⁰⁶ President G. W. Bush. (2006). Reforming Health Care for the 21st Century. The White House National Economic Council. Retrieved from http://georgewbush-whitehouse.archives.gov/stateoftheunion/2006/healthcare/healthcare_booklet.pdf
- ¹⁰⁷ The White House-Office of the Press Secretary. (2011). Presidential Proclamation – National Health Information Technology Week. Retrieved from <http://www.whitehouse.gov/the-press-office/2011/09/12/presidential-proclamation-national-health-information-technology-week>
- ¹⁰⁸ In 2004, President G. W. Bush launched an initiative to increase the seamless linkage between healthcare providers and patients. With the passing of the American Recovery and Reinvestment Act, President Obama invested in electronic health records and their usage to increase quality of care and decrease cost within the healthcare industry. Both President G.W. Bush and President Obama agree that increased utilization of EHR technology will boost efficiency, cut healthcare expenditures and improve care quality by reducing medical errors.
- ¹⁰⁹ Cebul, Randall, T. Love, A. Jain., and C. Herbert. (2011). Electronic Health Records and Quality of Diabetes Care. *The New England Journal of Medicine*. 365:825-833. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMsa1102519#t=abstract>

- ¹¹⁰ Finkelstein, Eric, Trogon, Justin, Cohen, Joel, et al. (2009). Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates. *Health Affairs*. Vol 28 no 5.
- ¹¹¹ Society of Actuaries. (2011). Press Release: New Society of Actuaries Study Estimates \$300 Billion Economic Cost due to Overweight and Obesity. Retrieved from <http://www.soa.org/news-and-publications/newsroom/press-releases/2011-01-10-obesity.aspx>
- ¹¹² Lindenauer RK, Remus D, Roman S, Rothberg MB, Benjamin EM, MA A, et al. (2007). Public Reporting and Pay for Performance in Hospitals quality improvement. *The New England Journal of Medicine*. 356 (5): 486-96. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMsa064964>
- ¹¹³ Governor Rick Snyder. *A Special Message from Governor Rick Snyder: Health and Wellness*. State of Michigan Executive Office. September 14, 2011.
- ¹¹⁴ U.S. Department of Health and Human Services - Meaningful Use Workgroup to the Health IT Policy Committee. (2009). *Meaningful Use: A Definition*.
- ¹¹⁵ U.S. Department of Health and Human Services - Centers for Medicare & Medicaid Services (2011). CMS EHR Meaningful Use Overview. *EHR Incentive Programs*. Retrieved from http://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp.
- ¹¹⁶ U.S. Department of Health & Human Services, The Office of the National Coordinator for Health Information Technology and Centers for Medicare & Medicaid Services.
- ¹¹⁷ State of Wisconsin laws: Chapter 441. Subchapter I, Regulation of Nursing. 441.001 Definitions.
- ¹¹⁸ *Occupational Regulation Sections of the Michigan Public Health Code*; MDCH Authority: P.A. 368 of 1978 as amended
- ¹¹⁹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition.
- ¹²⁰ Watson defines nursing “as a human science of persons and human health—illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (1988b, p. 54). In addition, she also views nursing as both a science and an art. *Watson, J. (1988b). Nursing: Human science and human care. A theory of nursing* (2nd printing). New York: National League for Nursing. (Original work published in 1985.)
- ¹²¹ Watson, Jean. (2008). *Nursing: The Philosophy and Science of Caring*. University Press of Colorado.
- ¹²² For more information on simulation technologies and their use, see *Final Report: Simulation Survey of Michigan Nursing Education Programs, 2010-2011*, available at www.micnwp.org.
- ¹²³ U.S. Department of Health and Human Services- Health Resources and Services Administration
- ¹²⁴ Benner P, Sutpen M, Leonard V, & Day L. (2010). Educating Nurses. *Carnegie Foundation for the Advancement of Teaching*. Information technology and simulation technology are suggested as a major tool in the development of nursing clinical judgment and improved transition to practice.
- ¹²⁵ Ibid.
- ¹²⁶ *Quality & Safety in the Education of Nurses*. See QSEN project website: www.qsen.org.
- ¹²⁷ Nurses often perform the function of interface between units of healthcare technology. When new healthcare technologies are added to an existing set of technologies, the interface often does not function well; nurses then become the means of translating the output of one testing or monitoring machine into the input of another. This is a diversion of nursing time that could otherwise be spent at the bedside; this issue needs to be addressed at the industry level and the system level.
- ¹²⁸ American Hospital Association. (2011). Standards for Hospital-Based Advanced Practice Nurses.
- ¹²⁹ Minneapolis Star Tribune (2010). *HealthPartners Unveils Online Diagnostic Tool for Common Ailments*.

MDCH – Task Force on Nursing Practice – Position Paper 9

Enable Competition and Entrepreneurship in Healthcare Markets

Recommendation: To improve access to safe, high-quality healthcare for Michigan residents, and consistent with Governor Snyder’s Regulatory Reinvention Initiative in support of competition, State government must make changes to the Michigan public health code (MPHC), Michigan limited liability company act (MLLCA), Michigan professional services corporation act (MPSCA) and other state statutes and regulations to ensure that professional nurses (Registered Nurses and Advanced Practice Registered Nurses) are authorized to: provide services in a learned profession; own and operate a Professional Limited Liability Company or Professional Services Corporation offering healthcare services to the public; and receive appropriate payment/reimbursement for these services from all payers and purchasers.

Summary of Issue

Restriction of Competition:

Many professional nurses (Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs)) in Michigan desire to become entrepreneurs and provide their professional healthcare services to the public responsibly and at competitive prices. The opportunity to start a professional healthcare company or corporation has been denied to professional nurses (RNs and APRNs), primarily due to outdated language in the Michigan Limited Liability Company Act (MLLCA) and Michigan Professional Services Corporation Act (MPSCA), as well as a lack of enabling language in the Michigan Public Health Code (MPHC). The business statutes use the 19th century definition of *learned profession*: “Services in a learned profession means services rendered by a dentist, an osteopathic physician, a physician, a surgeon, a doctor of divinity or other clergy, or an attorney-at-law.”¹ Thus, only physicians (MDs, DOs, podiatrists), surgeons, and dentists may provide professional health services² while operating as a Professional Limited Liability Company (PLLC) or Professional Services Corporation (PSC).³ This restriction of competition directly affects access to care, competition, and payment/reimbursement. Maintaining this restrictive regulatory environment is not logical at a time when the need for primary care and specialty care services is rising sharply.⁴ Over the next 10 years, at least two (2) million Michigan residents will require more healthcare services than they now use.

Professional nurses in Michigan are not permitted to own a PLLC or a PSC for the purpose of offering the healthcare services for which they are educated, licensed, and certified.⁵ APRNs may not directly offer healthcare services to the public in Michigan unless they are supervised by a physician; and may not be directly reimbursed for many of the healthcare services they are educated to provide. These restrictions hinder competition, discourage entrepreneurship, and decrease access to care.

Summary of Solution

Consistent with Gov. Snyder’s Regulatory Reinvention Initiative in support of competition, the State of Michigan must remove or modify statutes and regulations that were originally intended to protect the public, but are no longer needed.⁶ Changes are needed to relevant sections of the Michigan Limited Liability Company Act [Section 102(2)t and Article 9], the MPSCA, the MPHC, and related regulations to stipulate that RNs and APRNs (professional nurses) are among the “Learned Professions” and may own and operate PLLCs and PSCs, offering their professional healthcare services to the public.

Professional nurses must have the same right to own and operate a Michigan PSC or PLLC as the others listed under MLLCA Section 902(b) as providing professional services: “a certified or other public accountant, chiropractor, dentist, optometrist, veterinarian, osteopathic physician, physician, surgeon, podiatrist, chiropodist, physician assistant, architect, professional engineer, land surveyor, or attorney-at-law,” and a wide range of other licensed professionals. At a time when demand for healthcare services is increasing (and soon will exceed supply), it is only logical to promote entrepreneurship for professional

nurses and competitive healthcare costs for Michigan residents and other purchasers of healthcare services.⁷

Michigan cannot afford to lose the interstate competition for the services of professional nurses, which means we cannot afford mechanisms that restrain trade, limit competition and entrepreneurship, and deny Michigan residents the services of these educated, competent healthcare providers⁸ - many of whom want to become entrepreneurs, starting small businesses that provide jobs and pay taxes.⁹

Sub-Recommendations and Reasons

Recommendation 9a - Competition and Access to Care

To enable competition in healthcare markets, the government of Michigan must remove barriers that prevent competition and promote professional monopolies.¹⁰ APRNs must be authorized to do business as healthcare providers: forming and operating PLLCs and PSCs; providing the healthcare services that they are educated, certified, and licensed to provide; and receiving direct payment/reimbursement for those services.

Reasons for Recommendation 9a - In 2011, the Federal Trade Commission-Office of Policy Planning, Bureau of Economics, and Bureau of Competition issued invited opinions on Bills before the Florida House (HB 4103) and the Texas Senate (SB1260 & SB 1339), concerning the regulation of APRNs. The Bills removed physician supervision¹¹ and delegation requirements from APRNs, “allowing these healthcare professionals to practice to the full extent of their education and training.”¹² The FTC staff reviews indicate that “the Bills’ elimination of physician supervision and delegation requirements appears to be a procompetitive improvement in the law that likely will benefit Texas (and Florida) health care consumers.”¹³

“Effective competition is at the core of America’s economy. ...Health care competition is of particular importance to the economy and consumer welfare. For this reason, anticompetitive restraints in health care markets have long been a key focus of FTC law enforcement, research, and advocacy. ...Recently, FTC staff urged several states to reject or narrow restrictions that curtail competition among health care providers and professionals because they limit patients’ access to health care and raise prices.”¹⁴

In particular, FTC staff examined APRN scope of practice restrictions that appear to have exceeded what is necessary to protect consumers. “...Researchers have compared physician and APRN patient outcomes and found them comparable; no findings have shown better health outcomes for patients in states with more restrictive regulatory environments. ...More broadly, the available empirical evidence indicates that APRN-delivered care across settings, is at least equivalent to that of physician-delivered care as regards safety and quality, and that increased APRN care may even be associated with improved outcomes for particular disease indications or patient populations.¹⁵ ...Twenty states and the District of Columbia allow APRNs to practice as autonomous, or very nearly autonomous, healthcare providers.”¹⁶ The benefits of increased competition in healthcare markets include improved access to care (particularly in rural areas), potential cost reductions, and greater availability of safe, high quality healthcare.

Recommendation 9b - Demographics, Healthcare Markets, and Access to Care

To meet the healthcare needs of Michigan’s burgeoning over-age-65 population and prevent a major decrease in access to care for all Michigan residents, State government must increase the number of competent, licensed healthcare professionals by authorizing APRNs and RNs to practice to the full extent of their education and competencies. This will increase competition in healthcare markets, increase the availability of safe, high quality health care services, potentially reduce costs, and increase access to primary and specialty care.

Reasons for Recommendation 9b - Demographics of Demand: Michigan's anticompetitive restrictions are of particular concern at a time when: a) 100,000 Michigan Baby Boomer residents per year (for the next 20 years) are turning 65¹⁷ and requiring more healthcare services for chronic diseases; and b) an estimated 1.5 million Michigan residents will become eligible (starting in 2014) to acquire health insurance either through Medicaid or through subsidized purchase of private insurance on the Michigan Health Insurance Market.¹⁸ Over the next ten years, at least two (2) million Michigan residents will require more healthcare services than they now use. Rural sections of Michigan already are experiencing healthcare services demand exceeding supply; Certified Nurse Practitioners and Certified Nurse Midwives are often the major sources of primary care in rural areas. Certified Nurse Anesthetists are a critical resource for small rural hospitals, which otherwise would not be able to attract a surgeon or offer surgical services.¹⁹

Demographics of Supply: The retiring Baby Boom generation includes many nurses and physicians; their retirement decreases the supply of healthcare providers as demand is rising. Where will we get the healthcare professionals to provide care to those who need care? There are national and state shortages of primary care physicians, particularly geriatricians,²⁰ and those who remain often restrict the number of new patients they will take. Even after they are added to the patient roster of a primary care physician, new patients may wait months for their first appointment. APRNs provide healthcare equivalent to that provided by primary care and some specialty physicians. At 2.7 APRNs per 10,000 residents, Michigan is 43rd out of 50 states plus Washington DC (8th from the bottom) for number of APRNs per 10,000,²¹ even though Michigan universities have 20 nursing master's degree or nursing doctoral degree graduate programs educating 200-300 new APRNs each year. There is strong survey evidence from universities with such graduate programs that at least one-third of Michigan's newly graduated APRNs annually leave our state to work in states providing a more supportive and competitive regulatory environment for APRN practice.²²

Healthcare Workforce Markets: RNs and APRNs are valuable healthcare workforce resources, and are about to become even more valuable on the national market. If Michigan does not provide a competitive and supportive regulatory and business environment for RNs and APRNs, these healthcare providers will leave Michigan, further decreasing the healthcare workforce and the supply of healthcare services, depriving the public and healthcare organizations of the benefits of competition in the healthcare provider market, and depriving the State of the jobs and taxes generated by nursing companies.

Recommendation 9c - Remove 19th Century Restrictions from 21st Century Healthcare

The government of Michigan must *either*: add APRNs and RNs to the list of "Learned Professions" in the MLLCA, MPSA, and other statutes and regulations; *or* remove the Learned Professions Doctrine as the basis of special statutory treatment by reference, and instead specifically list all licensed professions with full autonomous practice (always including APRNs and RNs) in all statutes and regulations currently based on the Learned Professions Doctrine.

Reasons for Recommendation 9c - The "learned professions doctrine" was originally developed in the 1800s as medicine developed educational programs (in addition to apprenticeships, now called residencies) and degree-holding physicians wished to share in the status of the long-established professions of law and clergy. The doctrine is based on a British model in which physicians and surgeons are separate medical categories. Originally intended to emphasize the duties of lawyers, doctors, and clergymen to their clients, patients, and parishioners - thereby protecting the public - the doctrine has developed into a guarantor of monopoly. The doctrine is enshrined in all Michigan statutes referring to the "learned professions." The doctrine restricts or prevents competition for all of the listed "learned professions," maintaining quasi-monopolistic conditions that do not benefit the public. Legal precedent is a stabilizing concept;²³ however, in times of rapid change, it serves monopoly rather than the public interest. This is especially true in healthcare services, where demand is about to exceed supply.

APRNs and RNs must either be added to the “learned professions doctrine” or be specifically listed in all relevant statutes and regulations as fully autonomous healthcare providers with authorization to practice to the limits of their education and competencies, and authorized to own and operate PLLCs and PSCs. This must be accomplished to prevent a major decrease in access to care for all residents of Michigan, while increasing competition in healthcare markets and continuing to protect the safety and health of the public.

MLLCA Restrictions on APRNs and RNs: MLLCA Article 9, section 904 (2) states that “Except as provided in subsection (3) or (4), if a professional limited liability company renders a professional service that is included within the public health code, 1978 PA 368, MCL 333.1101 to 333.25211 [all licensed health professions], then all members and managers of the company must be licensed or legally authorized in this state to render the same professional service.” MLLCA section 904 (3) authorizes physicians to own PLLCs with other categories of physicians,²⁴ but RNs and APRNs are not mentioned and therefore are not authorized to own and operate PLLCs.

MPSCA Restrictions on APRNs and RNs: The Michigan Professional Services Corporations Act of 1962 “enabled members of the learned professions (attorneys, physicians, and clergy) to form businesses rendering services in which *service* and not *corporate profitability* was the organizing principle, as outlined in the learned professions doctrine.”^{25 26} After 1962, the Commercial Services Bureau included a widening range of other professions in the learned professions doctrine.²⁷ This changed in 2007/2008, due to a series of rulings by the Michigan Supreme Court and Court of Appeals in the case of *Miller v Allstate Insurance Company*; some 40 licensed professional occupations were expected to be required to re-incorporate.^{28 29} In response to this projected bureaucratic overload, the Commercial Services Bureau narrowed the range of professions included under the learned professions; indeed, the learned professions are right back to law, medicine, and clergy, with architects and building engineers included to some degree. While not directly relevant to APRNs or RNs, the Miller case rulings have *de facto* returned the healthcare professions regulatory apparatus to the highly restrictive 19th century.

Michigan Healthcare Workforce Implications: To avoid this restraint of trade³⁰ (see Federal Trade Commission opinions referenced), about one-third of Michigan-educated RNs and APRNs have emigrated to other states to own, register, and operate their nursing PLLCs and LLCs, thus removing their healthcare services from Michigan and depriving the State of the jobs and taxes generated by their companies. Considering the disparity between developing demand for healthcare services and the current and projected supply of healthcare providers, now is an appropriate time to add RNs and APRNs to the “learned professions doctrine” in all statutes and regulations referring to said doctrine - or list APRNs and RNs in the MPHC as autonomous practitioners to the full extent of their education and competencies - and enabled to so practice by the MPHC and all statutes and regulations currently referencing the learned professions doctrine.

Who Will Benefit from the Recommended Solution?

The public will benefit from improved access to safe, high-quality healthcare services with competitive costs, and from jobs created by nursing companies.

Nurse-employers will benefit from an expanded healthcare workforce and a greater range of competitive, high-quality healthcare contractors to provide needed services in hospitals and the community.

Other healthcare professionals will benefit from the availability of well-educated, experienced nursing partners, with whom companies may be established, high-quality healthcare services may be provided, and interprofessional patient care teams may be formed. Under all practice arrangements, APRNs and RNs will continue to refer patients to physicians when appropriate. This will improve the overall

healthcare environment, improve professional communications, reduce stress on physicians, and level the playing field for a wide range of healthcare providers.

Professional nurses will benefit from a clear, supportive regulatory environment in Michigan that encourages them to remain in the state, providing healthcare services to residents, setting up companies, hiring staff, and paying taxes.

Background: Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP was composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met from December 2010 through April 2012, gathered information, consulted with state and national experts in nursing practice and policy, and considered issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The issue of Enabling Competition and Entrepreneurship in Healthcare Markets was determined by the TFNP to be high priority.

End Notes

¹ Osteopathic physicians and dentists were added to the “learned professions” definition in the 20th century. The separate listing of physicians and surgeons is characteristic of the 19th century British definition used by American lawmakers seeking to protect the public from “quackery” by regulating medicine. In the 19th century, physicians, attorneys, and clergy were often the only persons with education beyond high school (or even grade school) in most American towns and villages. [See *Annual Reports of the Michigan State Board of Health, 1873 to 1900.*]

² MLLCA, Article 9 section 902 defines “professional service” as “a type of personal service to the public that requires as a condition precedent to the rendering of the service the obtaining of a license or other legal authorization. Professional service includes, but is not limited to, services rendered by a certified or other public accountant, chiropractor, dentist, optometrist, veterinarian, osteopathic physician, physician, surgeon, podiatrist, chiropodist, physician’s assistant, architect, professional engineer, land surveyor, or attorney-at-law.”

³ Filing as a corporation under the Michigan Professional Services Corporation Act is required to be eligible to receive payment/reimbursement for professional health services rendered by a corporation.

⁴ See MDELEG/MDLARA, *Healthcare Workforce Projections for Michigan*, 2011.

⁵ Abstract of a Nursing Practice Issue Statement Received by the TFNP: “RNs with 15 years or more of experience in nursing serve as case managers to auto injury survivors under the Michigan Auto No Fault Laws and the code of practice of the national professional organization, Case Manager Association of America (CMAM). This organization advises RN Case Managers to create their businesses as LLCs; however, if they put RN on their Michigan LLC application, it is denied due to the antiquated Public Health Code Article 2 (at least that is what the Corporations Division is quoting). They also are denied because of the decision in the Miller Case and the Attorney General’s decision about 4 years ago. Our laws need to acknowledge that Case Management is needed to support people through our medical maze and to do that they (case managers) need to be able to practice as legal entities in Michigan. There are hundreds of Case Managers nationally that abide by the Standards of the CMSA and deliver services to the public in all areas from geriatric services to auto survivors to workman’s comp, etc. It seems unconstitutional to deny our ability to have an LLC business to give care legally in the State of Michigan.”

⁶ See Reasons for Sub-Recommendation 9a, Federal Trade Commission opinions.

⁷ Pittman, P et al, “Independent practice for nurse practitioners does not negatively impact physician income.” *Nursing Research and Practice*, 2012. Using data from the Bureau of Labor Statistics, “we found no evidence of negative economic impact on family physician and internists in states that have already implemented reforms (16 states and WDC).” George Washington University, Washington, DC.

⁸ See TFNP recommendation and position paper 1, *APRN Definitions, Titles, Licensure, and Practice* for multiple research references supporting the equivalence of care received from APRNs with care received from physicians.

⁹ Abstract of a Nursing Practice Issue Statement Received by the TFNP: “APRNs and RNs can apply for Michigan LLC status as long as they don’t mention that they are RNs and don’t mention that they want to provide healthcare services to the public. They can provide systems analysis expertise to hospital systems and recommend major changes in healthcare service systems, but they cannot mention any of the healthcare services they could provide as nurses. This is not in the public interest, and not only constitutes restraint of trade (see recent opinions published by the Federal Trade Commission), but also is motivating APRNs and RNs who want to provide healthcare services to emigrate to states where the LLC and PLLC laws are not as out of date and discriminatory.”

¹⁰ From the 1850s through 1961, the professions of medicine, law, and clergy were considered to be service professions whose regulation was designed to protect the public from “quackery” (i.e., fake professionals), and whose service obligations prevented the formation of corporations (see reference 11). Licensure of physicians was a mechanism ensuring that the practitioner had met minimum standards of education and experience before being permitted to offer healthcare services to the public. This pattern was repeated when nurses were licensed in Michigan, beginning in 1909. However, a mechanism originally designed to protect the public from unqualified physicians has served also to limit competition in the healthcare marketplace.

¹¹ The DHHS Center for Medicaid and Medicare Services (CMS) has pointed out that, in a state which does not require Certified Registered Nurse Anesthetists (CRNAs) to be supervised by a physician, the Governor of that state may override the CMS regulation requiring such supervision. This loophole has been accessed by several states (most notably Colorado in 2011) that have extensive rural areas needing the services of CRNAs in locations where few or no physicians are available for supervision. See *Health Affairs*, June, 2011.

¹² United States of America, Federal Trade Commission, Office of Policy Planning, Bureau of Economics, and Bureau of Competition. Florida House Bill 4103 (2006), 2011. <http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf>. United States of America, Federal Trade Commission, Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Texas Senate Bill 1260 and 1339, 2011. <http://www.ftc.gov/os/2011/03/V1100004campbell-florida.pdf>.

¹³ Ibid, Texas, p 1.

¹⁴ Ibid, Texas, p 4.

¹⁵ Ibid, Texas, pp 2-4; Florida, pp 2-4.

¹⁶ *Texas Budget Board Staff Report*, January 2011. Quoted in Ibid, Texas, p 4. See also *The Future of Nursing*, Institute of Medicine, 2011; pp 157-61.

¹⁷ 2011 was the year when the first members of the Baby Boomer generation (nearly 80 million Americans) had their 65th birthday. Until 2030, about 10,000 American Baby Boomers per day will turn 65; in 2030, nearly 20% of Americans will be over the age of 65, compared to 13% today (Pew Research Center, 2011). In Michigan at present, about 20% of the population is over the age of 65, and we expect 30% of the population to be in this group by 2030 (MDELEG/MDLARA, *Healthcare Workforce Projections for Michigan*, 2011). Generally, older people require more healthcare services. Our burgeoning over-65 population has multiple chronic conditions and will require greatly increased amounts of healthcare services. This huge aging population has been called “The Silver Tsunami,” threatening to overwhelm the capacities of the healthcare system and the healthcare workforce.

¹⁸ See MDELEG/MDLARA, *Healthcare Workforce Projections for Michigan*, 2011.

¹⁹ S. Skillman, L. Kaplan, M. Fordyce, *et al*, February 2012. *Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data*. University of Washington School of Medicine, Department of Family Medicine, p4. “These findings imply that practice autonomy should be considered as a state-level strategy to encourage rural practice by NPs and CRNAs.”

²⁰ A shortage of physicians (primary care physicians in particular) has already begun. In 2011/12, the federal DHHS increased National Health Service Corps funding to educate physicians who will serve in shortage areas of the country. However, since it requires at least 8-10 years for new physicians to complete their training and begin offering healthcare services to the public, it is not feasible to meet current and future healthcare demand by simply expanding classes at medical schools.

²¹ S. Skillman, L. Kaplan, M. Fordyce, *et al*, February 2012. *Understanding Advanced Practice Registered Nurse Distribution in Urban and Rural Areas of the United States Using National Provider Identifier Data*. University of Washington School of Medicine, Department of Family Medicine.

²² United States of America. Federal Trade Commission, Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Texas Senate Bill 1260 and 1339, 2011. <http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf>.

United States of America. Federal Trade Commission, Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Florida House Bill 4103 (2006), 2011. <http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf>

²³ The Learned Professions Doctrine may be seen as having its roots in English Common Law and the Guilds of Medieval England. “Guild – any of various medieval associations as of merchants or artisans, organized to maintain standards and to protect the interests of its members.” *Random House Dictionary of the English Language, Unabridged*, 1987.

²⁴ MLLCA section 904 (4) stipulates that physician assistants may not own PLLCs unless at least one physician is a member of the company.

²⁵ Michigan House Fiscal Agency, Legislative Analysis, *Business Conversion Plans & Procedures, HB 5356*, Public Act 402 of 2008. Second Analysis, 2-2-09, p1.

²⁶ Ibid, p.6. Before 1962, the learned professions doctrine prohibited the professions of law, medicine, and divinity from practicing as corporate entities due to four principles: 1) laymen should not be permitted to practice medicine (which the corporate form might enable); 2) the physician/patient relationship could be destroyed by corporate shareholders interest in profit; 3) corporate limited liability might diminish patient trust in the physician; and 4) licensure and medical ethics, requirements of medical practice, cannot be fulfilled by a corporation.

²⁷ Ibid, p2. Osteopaths, ophthalmologists, and psychiatrists as well as certified public accountants, dentists, and psychologists were included under the learned professions doctrine and permitted to incorporate only under the provisions of the MPSCA.

²⁸ Ibid, p7. Public Act 402 of 2008 sought to avoid the cost and disruption of re-incorporation by providing for conversion from one corporate type to another with a \$50 filing fee. This statute was made largely irrelevant by the Michigan Supreme Court’s 2008 final decision to vacate the rationale in the Court of Appeals 2007 ruling on corporate status in the Miller Case.

²⁹ Ibid, p8: *Miller v Allstate Insurance Company*, COA docket No. 259992. This Court of Appeals ruling (on remand by the Supreme Court) stated that the physical therapy services rendered to Mr. Miller by PT Works were legally offered since the services had been provided by licensed physical therapists, and were, therefore, fully reimbursable. The Appeals Court also ruled that PT Works was improperly incorporated under the Business Corporation Act, rather than the MPSCA. In 2008, the Michigan Supreme Court vacated the rationale for this latter COA ruling.

³⁰ United States of America. Federal Trade Commission, Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Florida House Bill 4103 (2006), 2011. <http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf>.

United States of America. Federal Trade Commission, Office of Policy and Planning, Bureau of Economics, and Bureau of Competition. Texas Senate Bill 1260 and 1339, 2011. <http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf>.

This page intentionally left blank

MDCH – Task Force on Nursing Practice – Position Paper 10

Establish the Michigan Nursing Practice Council

Recommendation: It is recommended that the Director of MDCH assign to the Office of the Chief Nurse Executive the responsibility for creating and maintaining the Michigan Nursing Practice Council (MNPC), an overarching leadership group with staff resources to support planning, implementation, and evaluation of the Task Force on Nursing Practice (TFNP) Recommendations and appropriate nursing practice initiatives.

Summary of Issue

As stated in the Task Force on Nursing Practice (TFNP) vision statement, “Michigan’s nurses provide the public with safe high-quality healthcare by practicing to the full extent of their education and competency.”¹ Demand for healthcare services is increasing and will continue to rise as Michigan’s percentage of residents over age 65 grows.² Older people have more chronic health conditions requiring the use of more healthcare services. In addition, an estimated 1.5 million Michigan residents will become eligible (starting in 2014) to acquire health insurance either through Medicaid or through subsidized purchase of private insurance in the Michigan Health Insurance Market, further increasing healthcare demand. Registered Nurses (RN) are the largest group of health care professionals (there are over 145,000 RNs in Michigan),³ providing care in a wide range of settings.⁴ RNs are critical to the health and safety of the residents of Michigan. With the shortage of health care professionals, both in Michigan and the nation, additional health care providers will be needed to meet the healthcare demand and needs of all Michigan residents.

Summary of Solution

It is recommended that the Director of MDCH assign to the Office of the Chief Nurse Executive the responsibility for creating and maintaining the Michigan Nursing Practice Council (MNPC), an overarching leadership group with staff resources to support planning, implementation, and evaluation of nursing practice initiatives in Michigan. The MNPC (hereafter referred to as the Council) will advise the Office of the Chief Nurse Executive (or equivalent office) on the nursing practice environment in Michigan.

The creation and implementation of the Council will support efforts to implement the nine (9) TFNP Recommendations and to structure change that will protect patient safety while advancing the healthcare, regulatory, and business environments of Michigan. The Council may also advise the OCNE on additional nursing practice matters in Michigan that share the overall mission of advancing nursing practice and healthcare, and align Michigan with national and state standards. The Council may collaborate with the Michigan Board of Nursing and other stakeholders to further advance nursing practice by analyzing current and future factors affecting the Michigan nursing community and developing plans for improvement.

The Michigan Nursing Practice Council will be charged to a) work toward the vision of the Task Force on Nursing Practice: *Michigan’s nurses provide the public with safe high-quality healthcare by practicing to the full extent of their education and competency*,⁵ and b) to build on the recommendations and momentum generated during the deliberations of the TFNP to ensure implementation of each TFNP recommendation and appropriate nursing practice initiatives.

TFNP Recommendations and Position Papers include:

- 1 - Improve Practice for Advanced Practice Registered Nurses
- 2 - Modernize Registered Nurses’ Scope and Standards of Practice
- 3 - Clarify Delegation of Nursing Functions
- 4 - Delineate the Practice and Role of Licensed Practical Nurses
- 5 - Update Regulation of Nursing Assistive Personnel

- 6 - Mitigate Human Factors in Patient Care Quality and Safety
 - 7 - Increase Practice Efficiencies in Nursing & Healthcare
 - 8 - Advance Technology in Nursing Practice and Healthcare
 - 9 - Enable Competition and Entrepreneurship in Healthcare Markets
-

Who Will Benefit from the Recommended Solution?

A unified and collaborative mechanism responsive to Michigan nurses and the healthcare needs of the public will benefit:

The people of Michigan, whose access to safe high quality health care will benefit as Michigan nurses are practicing to the full extent of their education and competencies as full partners in all healthcare settings.⁶

Nurses in practice will benefit and will gain representation, voice, and support for improving nursing practice and their work environments.

Healthcare organizations will benefit from improved operational efficiency. With nurses practicing to the full extent of their education and competencies, healthcare organizations will be able to provide more efficient and comprehensive care to patients. Healthcare organizations will have a clear understanding of nursing titles, roles, education and competencies.

Background: Michigan's strategic plan for addressing the nursing shortage, *The Nursing Agenda for Michigan*⁷, includes action steps to strengthen the nursing profession and workforce through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. The Michigan Department of Community Health (MDCH) convened the Task Force on Nursing Practice (TFNP) in December 2010 to make recommendations to: a) the Director of MDCH regarding needed changes in statutes, rules, and policies, and b) other healthcare stakeholders in order to improve nursing practice, thereby protecting the health and safety of Michigan residents. The TFNP is composed of representatives of nursing practice at all licensure levels (Licensed Practical Nurse, Registered Nurse, and Advanced Practice Registered Nurse) and all practice settings (hospitals, community-based care, and home-based care) nursing education programs, employers of nurses, plus representatives from the Michigan State Board of Nursing and other stakeholders. The TFNP met from December 2010 through April 2012 to gather information, consult with state and national experts in nursing practice and policy, and consider issues identified by the nursing community, stakeholders, and the MDCH Task Forces on Nursing Regulation and Nursing Education. The establishment of a Michigan Nursing Practice Council has been determined by the TFNP to be of high priority.

End Notes

¹ TFNP Vision Statement

² *Occupational Regulation: Michigan Public Health Code*. P.A. 368 of 1978 as amended.

³ This data includes Registered Nurses and Advanced Practice Registered Nurses and reflects Michigan Department of Licensing and Regulatory Affairs: Bureau of Health Professions data from January 2012.

⁴ Michigan Center for Nursing. (2010.) *Survey of Nurses Report 2010*.

⁵ The complete TFNP Vision for Michigan nursing practice in the future is: *Nurses practice to the full extent of their education and competencies as partners in the provision of healthcare in all settings. Michigan's nurses are guided by professional standards and supported by statutes, regulations, and institutional policies, as they provide effective evidence-based patient-centered healthcare. Michigan's nurses promote and protect the health and safety of the public.*

⁶ "The Future of Nursing: Leading Change, Advancing Health." (2010). Institute of Medicine and Robert Wood Johnson Foundation.

⁷ *The Nursing Agenda for Michigan, 2005-2015*, Developed and published by the Coalition of Michigan Organizations of Nursing (COMON) and the MDCH Office of the Chief Nurse Executive, 1st edition 2006; 2nd edition 2011.

Michigan Department of Community Health – Task Force on Nursing Practice

Appendices

Appendix A: TFNP History

TFNP Design Group

TFNP Interaction and Approval Rules

TFNP Implemented Organizational Structure Chart

TFNP Appointment Letter

TFNP Member and Expert Biosketches

Appendix B: Additional TFNP Products

Organization Framework for TFNP Issues

Crosswalk: Comparing National Standards with the Michigan Public Health Code

TFNP Information Gathered: Nursing Practice Issues Statements and Five Regional Forums

This page intentionally left blank.

Appendix A – TFNP History

TFNP Design Group – October & November 2010

The MDCH Office of the Chief Nurse Executive convened the TFNP Design Group in October 2010 to assist in planning the composition, structure, and operations of the task force. The Design Group included representatives from nursing practice, nursing education, nursing regulation and other stakeholders:

- Elizabeth Henry, RN, MN, Senior Vice President Patient Care Services/Chief Nursing Officer, Sparrow Hospital & Health System
- Christine M. Pacini, PhD, RN, Professor and Dean, College of Health Professions and McAuley School of Nursing, University of Detroit-Mercy
- Dennis Paradis, MPH, Institute for Health Care Studies, College of Human Medicine, Michigan State University
- Joanne M. Pohl, RN, PhD, ANP-BC, FAAN, FAANP, Professor, The University of Michigan School of Nursing; Principal Investigator, Institute for Nursing Centers
- Mary-Anne D. Ponti, RN, MS, MBA, CNAA-BC, Chief Operating Officer and Chief Nurse Executive, Northern Michigan Regional Hospital
- Marilyn Rothert, PhD, RN, Dean Emerita, College of Nursing, Michigan State University
- Carole Stacy, MSN, RN, Director, Michigan Center for Nursing
- Melanie B. Brim, MHA, Director, Bureau of Health Professions, Michigan Department of Community Health

Staff from the MDCH Office of the Chief Nurse Executive and the MPHI Center for Nursing Workforce and Policy also participated.

History & Context: The health and safety of Michigan residents require that nursing standards, nursing education, and appropriate nursing practice be modernized to meet current and future needs. *The Nursing Agenda for Michigan* includes action steps to address the nursing shortage and strengthen the nursing profession through changes in nursing education and credentials, enhanced standards of practice, and appropriate regulation. Michigan must maintain high quality health care and increase respect for professional nurses while supporting the nursing workforce. Considering the major changes being made in the healthcare system, the modernization of nursing practice is both timely and essential to assure that nurses may address the healthcare needs of Michigan's people. [See: *The Nursing Agenda for Michigan, 2006*; *Final Report of the MDCH Task Force on Nursing Regulation, 2007*; and *Final Report of the MDCH Task Force on Nursing Education, 2009*.]

MDCH Task Force on Nursing Practice - Design Group Charge

TFNP Structure: Review the range of issues and topics appropriate for TFNP consideration, as well as the environmental context (healthcare systems changes, population demographics, healthcare professions demographics, and national and state economies). Review the range of constituencies and professional communities that should be represented on the TFNP. With all of these factors in mind, design an organizational structure appropriate for the TFNP (Co-Chairs, committee of the whole, Steering Committee, Sub-Committees, consultant roles, staff roles, and other structural features).

TFNP Function and Process: Review the operating and communication mechanisms and guidelines of the Task Force on Nursing Education and consider the ways in which these may be modified to improve and align with the operations and outcomes of the TFNE. Consider both internal and external communications mechanisms (email, interactive public website, password-protected TFNP webpage for members, hearings, focus groups, and other communication mechanisms). Make recommendations as to appropriate operating and communication mechanisms and guidelines for the TFNE, within the framework established by the MDCH-OCNE.

TFNP Issues: Review the *Final Report of the MDCH Task Force on Nursing Regulation* and the *Final Report of the MDCH Task Force on Nursing Education*, focusing on the recommendations and position papers related to practice. Review the reports of national initiatives dealing with nursing practice, such as the IOM October 2010 report *The Future of Nursing*, the Carnegie Foundation 2010 report *Educating Nurses*, summaries of the Affordable Care Act of 2010 and other relevant materials. Identify nursing practice issues that are high priority and amenable to solution. Structure these issues as the initial set to be put before the TFNP.

Consider other topics relevant to the successful convening and operation of the TFNP and make recommendations to the MDCH-OCNE.

Design Group Recommendations to the MDCH Office of the Chief Nurse Executive:

TFNP Structure: The Design Group recommended a TFNP organizational structure including: Two Co-Chairs, both with substantial nursing practice experience; Task Force membership of about 25, with representatives from all levels of licensed nursing practice and all nursing practice settings, nursing education, nursing regulation (including the Michigan Board of Nursing), nurse-employers, and other stakeholders; the Design Group generated and approved a list of candidates to become members. *Ad hoc* Workgroups should be convened as major nursing practice issue groupings are identified; Workgroups would be dissolved after a Position Paper addressing each identified set of nursing practice issues is completed and approved. Experts and consultants may be identified to provide information and consultation to any of the Workgroups. Consider a TFNP Retreat after the first few meetings to provide intensive working time and input from national experts.

TFNP Function and Process: The Design Group recommended that the TFNP membership agree on operating rules to manage deliberations and decision-making. Considering the wide range of nursing practice issues expected to emerge, a robust communications structure is recommended for the TFNP, providing communications channels both within the task force and among the task force members, the nursing community, and the public. An interactive website with support for submission of nursing practice issues on-line, and with a password-protected section for TFNP member communications would be appropriate, as is communications staffing. Hearings or public meetings should be held to provide opportunities for the public and the nursing community to speak with the TFNP and discuss their nursing practice issues. Members should commit to email communications of TFNP materials and draft documents with reasonable response times. The Co-Chairs, membership, and Workgroups will all need to meet monthly, with teleconferences as needed.

TFNP Issues: The context of nursing practice is changing rapidly at both the state and national levels. The Design Group recommended that attention be paid first to the MDCH-OCNE documents: *The Nursing Agenda for Michigan*, *Final Report of the MDCH Task Force on Nursing Regulation*, *Final Report of the MDCH Task Force on Nursing Education*, and associated Michigan nursing policy documents. Nursing practice issues must be elicited from the Michigan Nursing community through nursing organizations, on-line, and at conferences. Close attention should also be paid to national initiatives to modernize nursing practice and education, including the IOM October 2010 report *The Future of Nursing*, the Carnegie Foundation 2010 report *Educating Nurses*, summaries of the Affordable Care Act of 2010, nursing practice and regulation initiatives of the National Council of State Boards of Nursing, and other relevant materials. To provide a foundation for the deliberations of the TFNP, the Design Group contributed to and reviewed the first 10 drafts of the *TFNP Organizational Framework* (see Appendix B), and suggested many references to inform TFNP deliberations. The Design Group recommended that the TFNP identify nursing practice issues that are high priority and amenable to solution. The MDCH-Office of the Chief Nurse Executive thanked the Design Group and has followed these Design Group recommendations in convening and supporting the Task Force on Nursing Practice.

Task Force on Nursing Practice: Interaction and Approval Rules

Ground Rules for Interaction

Members of TFNP agree to the following ground rules to facilitate effective and respectful communication:

- Make every effort to attend (in person or by phone) all meetings.
- Make every effort to be on time for meetings.
- All members are expected to participate and to contribute their perspective.
- Keep the focus on agenda items.
- Keep the discussion focused.
- Raise your hand to speak; a facilitator will keep a list of the order in which hands were raised.
- Wait to be recognized before you speak.
- Only one person may speak at a time.
- Do not interrupt others or monopolize the communication.
- During the meeting, turn off all cell phones and beepers.
- When speaking, be brief and to the point; try to give examples.
- When speaking, explain the reasons behind your statements and ask for feedback from the group.
 - Ask questions to understand the rationale and data behind the positions of others.
- Speak to be understood, not to win.
- Be sensitive to differences in perspectives.
- Discuss issues, rather than debating them; do not assign blame.
 - Avoid personal attacks, cheap shots or loaded questions.
 - Don't assume motives behind the statement of others. Assume positive intent.
 - Test your assumptions and inferences by asking questions.
 - Define important words and agree on what they mean.
- Resist defending positions; rather, look for common ground and areas of agreement.
- Establish a "parking lot" for issues agreed to be important, but whose disposition is not yet clear. Periodically revisit the parking lot to review the issues therein; ultimately decide whether to bring such issues out into the mainstream, or to refer them to another entity.
- Refer inquiries to the TFNP webpage for updates on Task Force progress and the information-gathering activities of the TFNP. The TFNP webpage is maintained by the MPHI-Center for Nursing Workforce & Policy; see www.cnwp.org.

Ground Rules for Approvals

Members of TFNP agree to the following ground rules to facilitate decision making:

The Task Force on Nursing Practice will use the *Consensus with Qualification* procedure to make decisions. *Consensus with Qualification* does not mean 100 percent agreement on everything by all members. The following three conditions must be met to reach *Consensus with Qualification*:

1. All members agree that the information in the proposed document is factually correct.
2. Each member is at least 80% comfortable with the proposed document and the member's organization will not oppose it.
3. With regard to the final product (not individual proposals or components, but rather the final recommendations), 80% of members are satisfied.

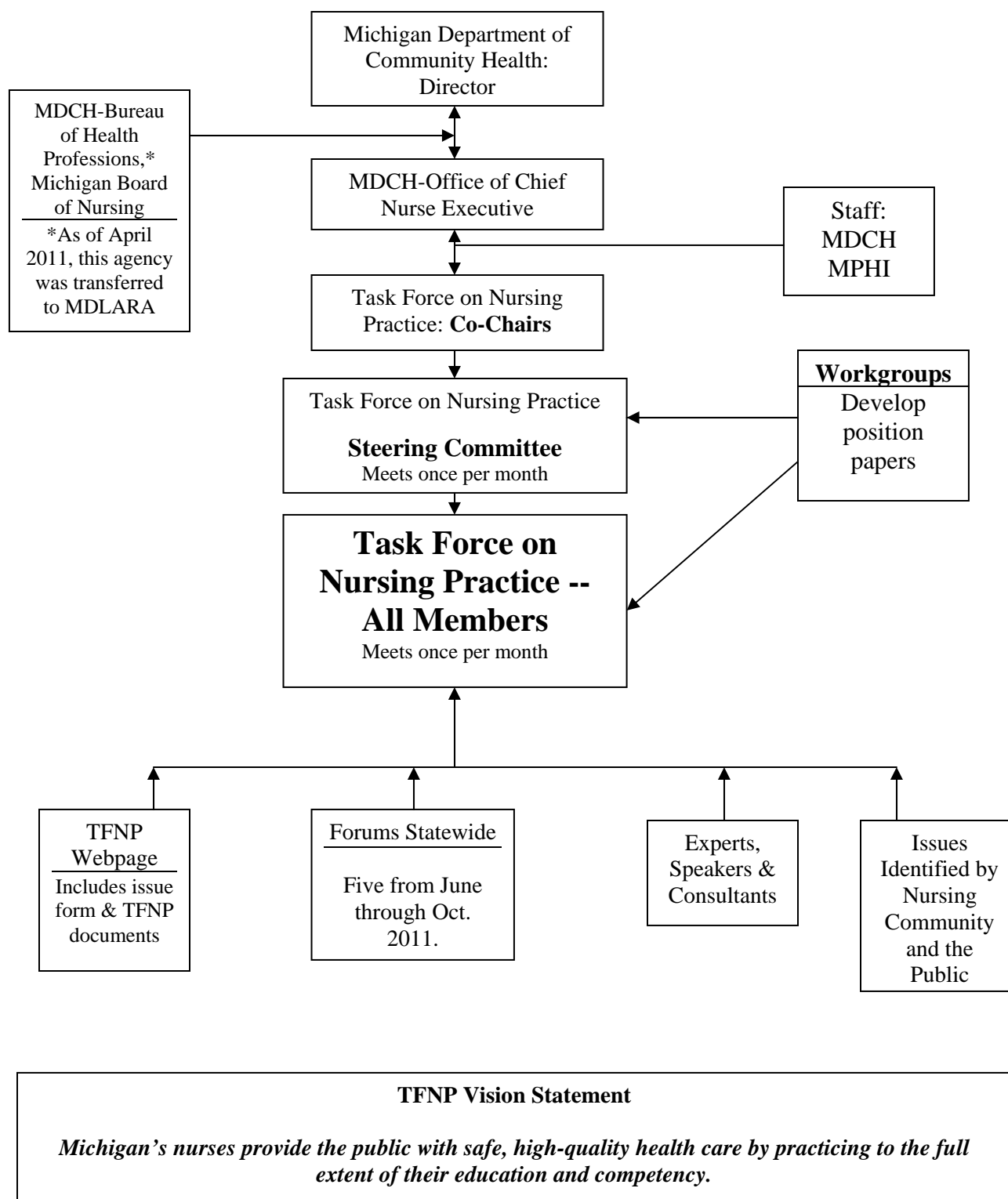
The process to reach *Consensus with Qualification* will assure that all concerns have been heard, understood, and addressed to the fullest degree possible and to the satisfaction of the group.

For decision items, the following steps will occur:

- a. Proposals are presented and clarified to the group. Whenever possible, proposals will be distributed in advance of the meeting.
- b. Members grade the proposal as:
 - 1) Totally agree
 - 2) Can live with it (see #2 above)
 - 3) Have legitimate concerns (for example, consequences of the proposal that are contrary to the goals of the group)
- c. Concerns are listed and addressed by the group. Changes can be made to the proposal if the group agrees.

If the group fails to reach *Consensus with Qualification*, members will clarify their objections and the TFNP Co-Chairs will make a decision with the input from the group.

MDCH -- Task Force on Nursing Practice Implemented Organizational Structure





JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

November 24, 2010

Dear TFNP Candidate:

Michigan's strategic plan for dealing with the nursing shortage, *The Nursing Agenda for Michigan*, includes action steps to strengthen the nursing profession and workforce through changes in nursing practice through enhanced standards of practice and appropriate regulation.

Today's rapidly changing patient population needs and the systemic changes in healthcare reform compel us to examine and modernize nursing practice, policy and regulation in support our nursing workforce and the patients they serve.

To that end, MDCH Office of the Chief Nurse Executive (OCNE) is preparing to convene the MDCH Task Force on Nursing Practice (TFNP). You are invited to serve on the Task Force that will begin meeting on December 6, 2010 at the Michigan Department of Community Health, in Lansing from 10:00am to 3:00pm. The Task Force on Nursing Practice will gather information, consider identified issues and their context, and ultimately make recommendations in a final report to be presented to the Director of MDCH with respect to solutions and next steps. The TFNP is expected to meet in person or by teleconference from December 6, 2010 through February, 2011.

- **The Charge to the TFNP is to make recommendations to the Director of MDCH regarding needed changes in statutes, rules, and policies in order to modernize the practice of nursing and the practice environment for nurses in Michigan, thereby protecting the health and safety of Michigan residents.**

I hope you will join us in this important endeavor. Your education, experience, and expertise will enhance the knowledge base of the TFNP, add value to its deliberations, and inform the recommendations that the Task Force is charged to produce.

Please return the enclosed Member Information Form to the Office of the Chief Nurse Executive, indicating your willingness to serve as a member of the TFNP, or to serve as a topic expert if you are not able to commit to the full Task Force schedule. Please fax (517/241-1200), email, or mail your form by November 30, 2010. Also enclosed are an Overview of the TFNP, the meeting schedule of the TFNP and a chart of the structure of the Task Force.

If you have questions, please contact the Chief Nurse Executive, Jeanette Klemczak, at 517/ 241-9841 or email to klemczakJ@michigan.gov. In the interest of efficiency and cost savings, all future communications will be sent to you electronically.

We look forward to working with you on this challenging and important project.

Sincerely,

Janet Olszewski
Director

Enclosures: Member Information Form, TFNP Overview, TFNP Meeting Schedule, TFNP Structure Chart

Task Force on Nursing Practice – Member and Expert Biosketches

James P. Fischer, MS, MBA, RN, NEA-BC, [TFNP Co-Chair], currently serves as Vice President, Patient Care Services and Chief Nursing Officer at Munson Medical Center in Traverse City, Michigan. He is also a Magnet appraiser for the American Nurses Credentialing Center. Mr. Fischer previously served as Director of Acute Care Services at Sparrow Hospital in Lansing and as a staff nurse and clinical nurse manager at St. Joseph Mercy Hospital, in Ann Arbor. During his 33 years of experience, he has lead Munson to Magnet Recognition status and electronic health record implementation, launched the open heart program at Sparrow Hospital, and also initiated numerous quality improvement efforts strengthening nursing practice. Mr. Fischer received a BSN from Eastern Michigan University and MS and MBA degrees from the University of Michigan.

Christine M. Pacini, PhD, RN, [TFNP Co-Chair] serves as the Dean of the College of Health Professions & the McAuley School of Nursing at the University of Detroit Mercy (UDM). Dr. Pacini previously served as the Clinical Director of Professional Development, Research & Innovation for Nursing at the University of Pennsylvania Health System. She held similar positions at the University of Michigan Health System, Indiana University Health System, and Henry Ford Hospital. She has experience in educational transformation and leadership development, and has been recognized for her service to education by UDM, the University of Michigan Health System, and Clarian Health Partners. Dr. Pacini received her PhD from the University of Michigan, MSN from Wayne State University, and BSN from Mercy College of Detroit.

Melanie Brim, MHA, [Ex-Officio Member] is the Deputy Director for Policy and Planning at the Michigan Department of Community Health (MDCH). She previously served as the Bureau Director for MDCH Bureau of Health Professions, where she was responsible for licensing and regulation of approximately 400,000 health professionals, the Michigan Board of Nursing, and 25 health profession boards. Prior to her work at MDCH, she was Licensing Division Director for the Michigan Department of Consumer & Industry Services. Ms. Brim has over 36 years of experience in the healthcare field, including acute care, long term care, mental health, correctional health care, and physician practice management. She holds a BS in Medical Administration and an MHA degree from Indiana University.

Shari Carson RN, BSN, NHA, CRRN, CDON, is the Director of Clinical Supports and Services for NexCare Health Systems. She has served in multiple positions at NexCare Health Systems, including Regional Director of Operations and Nurse Consultant. In over 30 years of experience in sub-acute care and skilled nursing facilities, Ms. Carson has worked in every role from nursing assistant to nurse executive. She serves on many committees, including the Advancing Excellence Lane for Michigan. She is the President of the Michigan Chapter of NADONA and a member of the Academy of Fellows through NADONA. Ms. Carson received her ADN from St. Clair Community College, BSN from the University of Detroit Mercy, and is a Certified Director of Nursing and a Certified Rehabilitative Registered Nurse.

Katie Childs, RN, BSN, is a staff nurse at Spectrum Health Blodgett Hospital on an Orthopedics and Neuroscience/Spine unit and is the 1st Vice President of the Michigan Nursing Students Association. Ms. Childs received the 2011 Award for Outstanding Senior Project from the Grand Valley State University Frederik Meijer Honors College for her research on reducing death anxiety among student nurses. She received her BSN from Grand Valley State University in 2011.

Regina Crooks, RN, BSN, is a Personal Health Manager for the Calhoun County Public Health Department overseeing school nurses, clinic services, and Children's Special Health Care. She has over 28 years of experience in psychiatric nursing, plus experience, as a staff nurse, visiting nurse, and nurse manager at Oaklawn Hospital in Marshall, Michigan and Chelsea Community Hospital in Chelsea, Michigan. She serves on the board of the Calhoun County Child Abuse Prevention organization. Ms. Crooks received her BSN degree from Western Michigan University.

Elizabeth B. Henry, RN, MN, is Senior Vice President of Patient Care and Chief Nursing Officer at Sparrow Health System in Lansing, MI. She has over forty years of experience in nursing from staff nurse to the Nurse Executive role. As an Executive Nurse Leader, Ms. Henry has been the CNO in community-based, for-profit, and religion-based healthcare organizations. She recently led Sparrow Hospital's Nursing Division in achieving the National Recognition of Magnet for Nursing Excellence. Ms. Henry is a member of the Michigan State College of Nursing Advisory Board, Lansing Community College Nursing Committee, and Capitol Area Health Alliance. Ms. Henry received her ADN, BSN, and MSN degrees from the University of South Carolina.

Jeanette W. Klemczak, MSN, RN, FAAN, [Ex-Officio Member] is the former Michigan Chief Nurse Executive (2004 – 2012) and current Director of Healthcare Workforce Talent at the Michigan Workforce Development Agency. She has over 30 years of experience in nursing staff, leadership, and education roles with the City of Detroit, Wayne County Health Department, the Michigan Department of Public Health (now MDCH), and the College of Nursing at Michigan State University. Ms. Klemczak provides professional nursing leadership, as well as expertise and coordination in workforce and health policy development at both State and National levels. She is a Fellow of the American Academy of Nursing.

Mary Korsgren, LPN, is a member of the Board of the Licensed Practical Nurses Association of Michigan, representing Region 1. She currently works as a Licensed Practical Nurse (LPN) for St. Joseph Health System Home Care and Hospice. Ms. Korsgren has over 26 years of experience as a home and hospice care LPN. She graduated from the McPherson School of Nursing in 1965.

Mary Kravutske, PhD, RN, is the Administrator for Nursing Development & Research at Henry Ford Hospital in Detroit, Michigan. She has over 20 years of experience in nursing leadership, clinical care education, and nursing research. She received her PhD and MSN from Wayne State University.

Nancy C. Martin, MSN, RN, is the President and CEO of VitalCare, providing home health, hospice, and adult day care services. She has over 40 years of experience as a nurse educator, business owner, and health care executive at the Visiting Nurses Association, the Detroit Health Department, Wayne State University, and private non-profit and national home health care organizations. Her areas of expertise are care transitions from acute to post-acute services and chronic care management systems. She is the recipient of the Registered Nurses Association in Michigan (RN-AIM) Dorothea M. Milbrandt Nurse Mentor award. Ms. Martin earned her BSN and MSN from Wayne State University.

Charlotte Mather, RN, MBA, BSN, is the former Chief Nursing Officer at Genesys Regional Medical Center and the current Chief Nurse Executive for Sheridan Hospital, Sheridan, Wyoming. Ms. Mather participated on the steering committee of the Great Start Collaborative of Genesee County and is the legislative coordinator with the Association of Women's Health Obstetrics and Neonatal Nursing, where she works on several initiatives addressing infant mortality. She was awarded the Nightingale Award for Nursing from Oakland University. Ms. Mather was a Robert Wood Johnson Foundation Executive Nurse Fellow, and earned her BSN and MBA from Oakland University. [TFNP member from December 2010 through December 2011].

Patricia McCain, ADN, RN, BS, PSN, is the School Nurse Consultant-Saginaw Township Community Schools, consulting for 5,000 students in the Saginaw area, and President of the Michigan Association School Nurses (MASN). She has over 40 years of experience in nursing, including positions in hospital and medical office care, auditing for health management organizations, and Adjunct Faculty for Saginaw Valley State University Nursing Program-Coordinating School Health Presentations. As president of MASN she was successful in advocating for a Michigan State School Nurse Consultant. She was honored by MASN with the Presidential Award in 2010 for promotion of children's health and the advancement of school nursing practice.

Patrick Miller, RN, MBA, MHSA, FACHE, is the Senior Vice President, Chief Operating Officer for Hospice of Michigan. Mr. Miller is responsible for clinical care delivery, ancillary services, electronic health record (EHR), and pediatric and prenatal services. Prior to joining Hospice of Michigan he was the

Executive Director of Avalon Hospice in Flint. He began his career as a nursing assistant and held registered nurse positions in home health, long term care and hospital-based settings. His background also includes a cultural exchange program in the Middle East and a graduate fellowship with Diné College at the Navajo nation in Arizona.

Patricia E. Natale, RN, MSN, NEA-BC, has more than 35 years of professional nursing experience as a Nurse Practitioner, clinical leader, and executive. As the Chief Nursing Officer for an eight-hospital system for six years, she led three of the hospitals to receive Magnet Hospital designations. Ms. Natale was also influential in implementing system-wide electronic health records (EHR) and HIMSS Level 6 at the Detroit Medical Center, honored as the “most wired” system in Michigan. She has participated in Leapfrog, multiple JC specialty certifications, and several quality designations with the Michigan Health and Hospital Association.

MaryLee Pakieser, RN, MSN, FNP-BC, is a Nurse Practitioner at the Veterans Affairs clinic in Traverse City, and President of the Michigan Council of Nurse Practitioners. She has 40 years of experience advocating for an active nursing presence in all aspects of healthcare and health policy. She has experience in acute care in rural and urban settings, home care, free clinics, migrant health care, public health, pain management, and private family practices. Ms. Pakieser received the Carol Franck Nursing Leadership Award in 2006.

Linda Pekar, RN, BA, CLNC, CHPN, is Vice President of Clinical Operations at the Visiting Nurses Association of Southeast Michigan. She has 25 years of clinical and nursing executive experience in critical care, skilled nursing facility and sub-acute units, home health care, and hospice care. She is devoted to developing palliative care services for the fragile and chronically ill and has provided expertise to the National Hospice and Palliative Care Organization and the National Association for Home Care. Ms. Pekar has advanced certifications as a Legal Nurse Consultant and in Hospice & Palliative Care.

Amy M. Perry, MSN, RN, is a Clinical Operations Specialist for Blue Cottage Consulting and serves on the Michigan Board of Nursing. Ms. Perry has over 35 years of experience as a clinical practice leader for performance improvement, working as Assistant Director of Nursing for Psychiatric Services, Human Resources Special Projects Consultant, Director of Nursing Informatics, and Director of Quality Improvement at the University of Michigan Health System. She has developed strategies to integrate LEAN healthcare principles into system practices. Ms. Perry earned an ADN from Mercy School of Nursing, a BSN from the University of Toledo, and a MSN from the Medical University of Ohio.

Joanne M. Pohl, PhD, ANP-BC, FAAN, FAANP, is Professor Emerita, The University of Michigan School of Nursing; she serves as Principal Investigator for the Institute for Nursing Centers, and is past President of the National Organization of Nurse Practitioner Faculties (NONPF). She has more than 30 years of experience as a Nurse Practitioner, working primarily in nurse managed health centers with underserved populations. Her major professional interests are: quality care outcomes, cost of care, and implementation of electronic health records (EHR) in primary care settings serving vulnerable populations. In 2011, she received the Lifetime Achievement Award from NONPF for national leadership in NP education and nurse managed health centers.

Erin Savela, ADN, BA, is a staff nurse at St. John Health System, Macomb in the Clinical Decision Unit and President of the Michigan Nursing Students Association. Ms. Savela received the Outstanding Academic Student Leader of the Year Award from Macomb Community College. She received her BA from Oakland University and an ADN from Macomb Community College.

Laura A. Schmidt, MSN, FNP-BC, is the Director of Nursing & Allied Health at Northwestern Michigan College, an advisory board member for the Michigan Center for Nursing, and Ambassador for the National League for Nursing. She has over 35 years of clinical and educational experience as a RN and APRN. Elk Rapids presented her with its Woman of Achievement award in 2010. Ms. Schmidt is a DNP candidate at St. Louis University.

Kerri D. Schuiling, PhD, CNM, NP-BC, FACNM, FAAN, is Professor and Dean of the School of Nursing at Oakland University in Rochester, Michigan. She also is Sr. Staff Researcher for the American College of Nurse-Midwives and Co-Editor-in-Chief of the *International Journal of Childbirth*. Previously she was Professor, Associate Dean, and Director of the School of Nursing at Northern Michigan University in Marquette. Her major research areas are the APRN workforce, women's health, domestic violence, and care of women during birth. Dr. Schuiling received the Kitty Ernst Award for her endeavors in midwifery and women's health care.

Linda Scott, PhD, RN, NEA-BC, FAAN, is Professor and Associate Dean for Graduate Programs in Nursing at Grand Valley State University (GVSU) in Grand Rapids, Michigan. Her research has focused on the administration of nursing practice, nurse fatigue and patient safety, state and national patient safety agendas, and policy formation. Dr. Scott received her BSN from Michigan State University, her MSN in Nursing Administration from GVSU, and her PhD in Nursing from the University of Michigan.

Carole Stacy, MSN, RN, is the Vice President of the Michigan Health Council and provides leadership for the Michigan Center for Nursing and the Michigan Center for Health Professions where she manages projects collecting health workforce data and analyzing that data to discern trends. She also coordinates the annual Nursing Leadership Institute. Ms. Stacy has over 30 years of experience, previously serving as the State Supervisor of Curriculum and Program Development at the Office of Career and Technical Preparation, Michigan Department of Education. She was one of the lead designers of the National Healthcare Skill Standards, and implemented the national plan for secondary health science programs.

Linda Taft, RN, is Chair of the Coalition of Michigan Organizations of Nursing (COMON) and is a Contingent RN in POH/PACU at Macomb Township Surgery Center. Ms. Taft represents COMON on the Michigan-Area Health Education Council and Michigan Health Insurance Access Advisory Council. She previously served as Chair of the Michigan Board of Nursing. She received the Michigan Nursing Leader Award in 2007. Ms. Taft holds an ADN from St. Clair County Community College and LPN from Shapiro School of Practical Nursing.

Henry C. Talley V, PhD, CRNA, MSN, MS, BA, is Associate Professor and Director of the Nurse Anesthesia Program at the Michigan State University College of Nursing. Mr. Talley previously was nursing anesthesia faculty at the University of Tennessee, Arkansas State University, and the Uniformed Services University of the Health Sciences; he has 33 years of experience as a CRNA. He served as an officer in the US Army Reserve Nurse Corps from 1988 through 2010, with active duty in Southwest Asia; he retired as a decorated Reserve Lieutenant Colonel. Mr. Talley received the *Guiding Light* Award from MSU students in 2009. He earned his MSN and PhD from the University of Tennessee. His research interests are in anesthesia quality assurance.

Nancy D. Vecchioni, RN, MSN, CPHQ, is the Vice President of Medicare Operations at MPRO, Michigan's Quality Improvement Organization and is co-lead on the MI STA*AR project, a four year initiative to reduce hospital readmissions in Michigan. Her 20 years of healthcare experience include Administrative Director for Quality Outcomes & Patient Safety at Summerlin Hospital Medical Center in Las Vegas, Nevada; and Administrative Director for Infection Prevention and Control in the Oakwood Healthcare System; Clinical Nurse Specialist in Epidemiology for Annapolis Hospital, and clinical positions in oncology, intensive care, medical-surgical and operating rooms. She is focused on working with healthcare providers and community organizations to improve care quality and patient safety.

Kathleen Vollman MSN, RN, CCNS, FCCM, FAAN, is a Critical Care Clinical Nurse Specialist, Educator and Consultant. Her company, ADVANCING NURSING LLC, seeks to create empowered nursing work environments. Building on her 14 years of experience as a CNS at Henry Ford Health System, Ms. Vollman has published & lectured throughout North & South America and other countries on a variety of pulmonary, critical care, prevention of health-care-acquired injury, and professional nursing topics. She became a Fellow of the American Academy of Nurses in 2009. Ms. Vollman earned her BSN from Wayne State University and her MSN from California State University in Long Beach.

Teresa Wehrwein, PhD, RN, NEA-BC, is Associate Dean for Academic and Clinical Affairs at Michigan State University College of Nursing (MSU CON), research scientist at the Institute of Health Care Studies, MSU College of Human Medicine, and Principal Investigator on a Blue Cross Blue Shield of Michigan Foundation grant preparing curriculum for nurse case managers and quality/safety managers. Dr. Wehrwein previously served as Administrative Director for Nursing Development and the Center for Academic Nursing at Henry Ford Health System in Detroit and as professor at Madonna University in Livonia. She received the Nightingale Award for Nursing Education in 2007.

Task Force on Nursing Practice Workgroup Experts

Cynthia Archer-Gift, PhD, MSN, BSN, is an Associate Professor of Nursing and Assistant Chair for Psychiatric/Mental Health and Public Health Nursing at Wayne State University. She previously served as the MDCH Liaison to the Joint Commission on Accreditation of Healthcare Organizations for publicly operated hospitals and centers and as a reviewer for Community Mental Health treatment programs, where she conducted licensure inspections of psychiatric hospitals and hospital psychiatric units. Dr. Archer-Gift is the former Chief Psychiatric Nurse Consultant for the Michigan Department of Community Health (MDCH) Office of Psychiatric & Medical Services. She received the National Nursing Award from the Government of Trinidad & Tobago.

Andrea Bostrom, PhD, PMHCNS-BC, is Professor at the Kirkhof College of Nursing at Grand Valley State University in Grand Rapids, Michigan. Dr. Bostrom has over 20 years of experience teaching mental health nursing at undergraduate and graduate levels. She previously was a faculty member at Michigan State University College of Nursing. Her clinical interest and research focus is the comprehensive physical and psychosocial care of the severely mentally ill, particularly those who have schizophrenia or bipolar disorders.

Dianne Conrad DNP, RN, FNP-BC, is Family Nurse Practitioner at Cadillac Family Physicians, PC in Cadillac, and Assistant Professor at Grand Valley State University in Grand Rapids, Michigan and. She is Board Certified in Advanced Diabetes Management and a Certified Diabetes Educator. She received the Pinnacle Award for Diabetes Innovation in 2004.

Craig Huard, MSN, CRNA, MBA, is a Certified Registered Nurse Anesthetist at Port Huron Hospital and also serves as a clinical instructor. He has over 18 years of experience as a graduate Nurse Anesthetist instructor. He previously served as Simulation Coordinator for the Beaumont-Oakland Program of Nurse Anesthesia and Director of Operating Room services at Pontiac Osteopathic Hospital. He advocates for improving communication among APRNs, reforming healthcare regulations, and improving design and delivery efficiencies in Surgery. Mr. Huard received the Guiding Light award for his work with nursing students.

Katie Lavery, MS, BSN, CNM, RN, is a Certified Nurse-Midwife. She serves as a staff midwife at Bronson Women's Service and at Henry Ford West Bloomfield Hospital, and maintains her practice, "Everyday Blessings Health Care for Women," in Jackson, Michigan. She is Chair of the Michigan Board of Nursing, and the midwifery representative to the National Council of State Boards of Nursing, Advanced Practice Registered Nurse Committee. She earned her BSN from the University of Minnesota and MS from Columbia University.

Deborah Leblanc, BSN, MM, NEA-BC, is Vice President Patient Care Services/ Chief Nurse Executive at Detroit Receiving Hospital. She has over 30 years of experience as a staff nurse, nurse educator, business owner, and nurse executive. Previously, Ms. Leblanc was Chief Nurse Executive at Ingham Regional Medical Center and Hayes Green Beach Hospital. Her focus is on strengthening shared governance, quality improvement initiatives, and patient care delivery and nursing practice. She received her BSN from Northern Michigan University and her MM from Aquinas College.

Marie Patrick, RN, NHA, is Nursing Home Administrator at Holt Senior Care & Rehab Center, a 102 bed skilled nursing facility in Holt, Michigan. Ms. Patrick previously was Director of Nursing and Nurse

Consultant for geriatric nursing and long-term care facilities. Her expertise is in geriatric nursing and nurse management in skilled care settings. Ms. Patrick received her ADN from Montcalm Community College and is currently a BSN candidate at Kent State University.

TFNP Consultants

Olga Dazzo, MBA, was appointed by Governor Rick Snyder in January 2011 as Director of the Michigan Department of Community Health. She leads MDCH's work to improve health, health care, and access to health care while lowering costs. Ms. Dazzo previously was President and CEO of Health Reform Innovations, helping health care organizations improve services and lower costs in the midst of national challenges and reforms. For more than 10 years, she was President and CEO of Physicians Health Plan (PHP), which was consistently ranked among the best health plans in the nation in customer satisfaction. In 2002, Ms. Dazzo received the Ellis J. Bonner Outstanding Achievement Award from the Michigan Association of Health Plans for exemplary service in health care innovation. She holds a BA and an MBA in Finance from Michigan State University.

Rose Kearney-Nunnery, PhD, RN, currently is visiting Professor and Chair of the Department of Nursing at the University of South Carolina-Beaufort. She has over 30 years of clinical and education experience including work as a Charge Nurse at both Winter Haven Hospital in Winter Haven, FL and Methodist Hospital in New Orleans, LA. She has held nursing faculty positions at South University, Technical College of the Lowcountry, and Louisiana State University Medical Center. She has served as Chair of the NCSBN Committee on the Model Nursing Practice Act and Rules. She received the Dorothy M. Smith Nursing Leadership Award for Education from the University of Florida in 2010. Dr. Kearney-Nunnery earned a BSN from Keuka College, NY, and MSN and Ph.D. degrees in Nursing from the University of Florida, Gainesville.

Linda Kruso, BA, is Co-Lead of the Michigan Regional Action Coalition (designated by RWJF) and Director of Workforce Planning for Beaumont Hospitals. She is responsible for planning and developing programs and initiatives to enhance recruitment, engagement, and retention of Beaumont's workforce while also developing partnerships with education, government and community groups. Since assuming this role in 2005, Ms. Kruso has been responsible for developing Beaumont's talent acquisition and integration strategies. This has included the assessment and implementation of best-in-class applicant tracking and talent assessment tools. Beaumont has partnered with several colleges and universities to support accelerated nursing degree programs targeted at mature adults. Ms. Kruso earned a BA from Oakland University.

Rae Ramsdell, BA, is Director, Bureau of Health Professions at the Michigan Department of Licensing and Regulatory Affairs.

Matthew H. Rick, JD, is Director of the Office of Legal Affairs & FOIA at the Michigan Department of Community Health.

Appendix B – Additional TFNP Products

Organizational Framework for TFNP Issues

Preamble

Nurses in Michigan seek to promote and protect the health and safety of the public through excellence in professional nursing practice. This includes: safe, evidence-based, high-quality, patient-centered care delivered in an efficient and effective manner by nurses practicing to the full extent of their education and competencies. Nursing practice [LPN, RN, & APRN] includes an appropriate degree of autonomous practice, with Advanced Practice Nurses having fully autonomous practice as well as regulatory autonomy. Nurses are full partners in the delivery of healthcare services and are engaged in changing a) nursing as a profession and b) the healthcare system.

Major Principles:

- 1. Patient-centered care: Provide to the patient the right care at the right time in the right place. Patients should a) have seamless access to high quality, safe healthcare services and b) be prepared to collaborate with health professionals in making healthcare decisions.**
 - a. The quality and safety of the care provided to the patient should inform scope of practice, based upon professional education and experience.
 - i. No one discipline owns scope of practice, which follows the needs of the patient¹ for healthcare services delivered in an efficient and effective manner.
 - ii. The patient may be best served by a nurse, a physician, a member of another health profession, or a team of health professionals.²
 - iii. Improved communications and relationship-building are critical to creating an environment in which patients, communities, and all healthcare providers collaborate in healthcare decision-making, coordination of care, and advocacy for healthcare quality and safety.
 - b. Patient-centered care requires that patients have a) sufficient health literacy to collaborate in healthcare decision-making and b) received understandable information about their condition and options from health professionals.
 - i. After treatment options have been reviewed in terms understood by the patient, the needs and desires of the patient should be taken into account as decisions are made concerning treatment selection and provider selection.
 - ii. Provider scope of practice – now and in the future – should take into account what is best for the patient as an informed, engaged consumer of healthcare.
 - iii. Education of the public on healthcare provider scope of practice – now and in the future – will be critical for delineation and maintenance of the patient’s role in healthcare decision-making³.
 - iv. Nursing’s role in education of the public to improve health literacy and patient healthcare decision-making must be clearly delineated and included in scope of practice⁴.
- 2. The quality and safety of the care provided to the patient should guide the aspect of scope of practice termed “delegation”.**
 - a. Nursing delegation and supervision are defined in the Public Health Code (PHC) and Michigan Board of Nursing [MBON] Rules,⁵ where guidelines are provided;

however, de facto administration and practice may place nurses, their licenses, and their patients in jeopardy. (Issue referred to TFNP from TFNR.)⁶

- b. Delegation and supervision within nursing practice are the responsibility of nurses. However, the implementation of delegation and supervision is impacted by communications technology. Statutes and regulations require revisions to take new technologies into account as they affect nursing practice. Additional modalities for delegation, supervision, and monitoring of performance of delegated functions are enabled by communication devices with wireless text, voice, and video capacity. This virtual landscape for nursing interaction (i.e., delegation and supervision) was not envisioned even a decade ago.
- c. As nursing practice and the healthcare system evolve, knowledge and understanding of delegation as a continuum of nursing processes is needed, as is the will to put patient safety before economic expediency.
 - i. The general *delegation of nursing functions* issue centers around the conflict between statutes and rules covering delegation/supervision and the real-world pressures to decrease healthcare costs by shifting responsibility for nursing tasks to individuals with lower certifications and wages. How can patient care be made high-quality and safety maintained, while at the same time healthcare costs are held constant or decreased? Healthcare reform and a rebounding nursing shortage will amplify the difficulty of resolving this issue.
 - ii. The PHC and MBON Rules may need amending, but the question will be whether to adjust the regulations to fit current practice or to adjust practice to comply with current regulations, as well as those expected as a result of healthcare reform. Economic considerations often outweigh all others.
 - iii. Education on delegation and supervision should be required for nursing students (as a part of curriculum and licensure), practicing nurses (as a component of re-licensure), and for persons in a role dealing with delegation and supervision of nursing tasks.
 - iv. This complex issue requires in-depth review, substantive discussions, and careful framing of recommendations to the Director of MDCH.
3. **To ensure that high quality, safe healthcare services are provided to patients in all situations, it is important that all health professions define their core competencies and scope of practice, looking at the areas where there is overlap between professions and where each health profession is singular.**
 - a. For nursing, gather information on core competencies⁷, scope of practice⁸, and means of assessment and continuing evaluation⁹. Develop a recommendation that efficiently and effectively addresses nursing scope of practice issues and includes regulatory efficacy measures.
 - i. Work with national initiatives to accomplish this goal for nurses; recommend necessary changes in the Public Health Code (PHC) to align Michigan with national standards.
 - ii. Encourage initiatives to accomplish this goal for all health professions, with concomitant changes in the Public Health Code (PHC).
 - iii. Consider the utility (positives and negatives) of a Nursing Practice Act; consider other approaches to gain some of the positives and minimize the negatives of a Nursing Practice Act. Produce a “white paper” on practice acts.
 - iv. Consider licensure of health professions to be a regulatory mechanism with continuing assessment and evaluation built into re-licensure. Recommend necessary changes in the Public Health Code.

- v. Consider the policy and procedures workload implied in these projected TFNP issues and recommendations. Bureau of Health Professions staff are overburdened at present, and implementation of TFNP recommendations would increase regulatory burden for BHP staff and for the MBON. Consider the role, structure, and functioning of the current regulatory system: How do issues flow through the MDCH? Who addresses issues? Do they have the tools and resources needed to address these issues?
- vi. Consider the effects of demographic trends, increasing poverty, and health disparities in Michigan on the demand for healthcare services, particularly those related to chronic diseases, care coordination, and home healthcare. This includes the aging of Michigan's population between 2011 and 2030 (~100,000 turning 65 each year), increasing number of families with children living in poverty, and disparities in healthcare sought and received by ethnic/racial minorities¹⁰.
 - 1. The definitions of core competencies and scope of practice may need adjustment to appropriately provide healthcare to these populations.
 - 2. Ambiguity in the scope of practice for health professions may be tacitly encouraged by the systemic stresses of high demand for services and lower levels of reimbursement for those services.
 - 3. The balance between specificity and flexibility in the scope of practice and core competency definitions may be difficult to maintain under these conditions. Consider mechanisms for adjustment as needed.
 - 4. Health disparities and the maintenance of health equity are significant issues at the national, state, and local levels. The declining middle class and the increasing socio-economic gap between the working class and the upper-middle-class are trends that play out in the healthcare arena and demand innovative solutions.¹¹
- vii. Consider the effects of recent national initiatives such as: the Robert Wood Johnson Foundation – Institute of Medicine *Future of Nursing* report; the RWJF/American Organization of Nurse Executives report *Transforming Care at the Bedside* (2008/9); the Carnegie Foundation *Educating Nurses* and *Educating Physicians* reports; the American Nurses Association *Nursing Scope and Standards of Practice*, 2010; the *Magnet Hospital Principles* of the ANA; the multitude of initiatives dealing with the Primary Care Medical Home; the American Hospital Association workforce initiative; the AARP Public Policy Institute publications on nursing and the Affordable Care Act¹²; the AARP Center to Champion Nursing in America; and the Josiah Macy Foundation *Report on Primary Care*. All of these initiatives and publications seek major changes in the education and practice of health professionals, nurses in particular. The *Future of Nursing* report, the AARP reports, and *Educating Nurses* also take into account the likely effects of healthcare reform and (to some extent) the changing demographics of the country.
 - 1. Review these national initiatives for identified practice issues, other useful information, models, and guidelines to inform the work of the TFNP in the modernization of nursing practice.
 - 2. To the extent feasible, align TFNP recommendations with the recommendations of these national initiatives, so that TFNP recommendations will be reinforced and their credibility increased.
 - 3. To the extent feasible, align TFNP recommendations with the national initiatives, so that implementation of TFNP recommendations will produce projects eligible for the funding opportunities that will emerge as national initiatives are implemented.

4. Consider conflicts or non-alignment between TFNP recommendations and those of national initiatives as a signpost indicating need for careful review of the assumptions and conditions underlying TFNP recommendations.
- viii. Consider the effects and opportunities/challenges related to recent Michigan healthcare and nursing initiatives, some connected to national programs and some originated in the state. Leverage and coordinate the TFNP relationship to these in-state initiatives.
 1. The Robert Wood Johnson Foundation has selected Michigan as one of five states to pilot the implementation of the *Future of Nursing* recommendations (see national initiatives above). The Michigan Center for Nursing has convened a Regional Action Coalition (RAC), led by a Steering Committee of nurse leaders and stakeholders.
 2. As a parallel effort to the pilot projects, the RWJF also is funding an additional round of Partners Investing in Nursing (PIN) grants to partnerships with existing PIN grants. Michigan State University and the Michigan Center for Nursing are jointly applying for a PIN award focused on increasing the number of RNs with BSN degrees.
 3. MNEC – The MDCH Task Force on Nursing Education (2008/2009) recommended that a successor council to the TFNE be appointed by the MDCH Office of the Chief Nurse Executive. The Michigan Nursing Education Council (MNEC) held its first meeting in May 2010 and meets quarterly to oversee implementation of the TFNE recommendations (2010 priorities include national nursing accreditation for all pre-licensure education programs, quality & safety in nursing education, transition to practice programs, and APRN education and practice). The MNEC will consider additional nursing education issues as they arise, providing a forum for nursing educators, employers, and regulators to jointly assess issues and propose solutions in a systemic manner.
 4. The Michigan APRN Coalition has initiated a campaign to raise awareness of APRN practice in Michigan, the regulatory barriers that currently prevent APRNs from practicing to the full extent of their education and competency, and the likelihood that many APRNs educated in Michigan will leave the state, gravitating to states with regulations that support such practice. Since demand for healthcare is increasing (see 3a-vi above and 3a-ix below) and the number of primary care providers per capita is decreasing, Michigan needs to retain the APRNs currently practicing as well as those educated in the state; this requires changes in statutes.
 5. Keystone Center for Patient Safety & Quality was initiated by the Michigan Hospital Association in 2003. The Center has successfully used the Johns Hopkins collaborative model for transformational change, with a focus on improving organizational culture. The Comprehensive Unit-based Safety Program integrates communication, teamwork, and leadership to create and support a “harm-free” patient care culture. Nurses have been key participants in these collaboratives.
 6. In 2009, Michigan was one of three states selected by the Institute for Healthcare Improvement (IHI) to participate in a four-year statewide initiative to reduce avoidable rehospitalizations by 30 percent. The MI STA*AR pilot coalition included the state’s largest insurers, who provided standardized data on rehospitalization rates to participating

hospitals. The hospitals set up teams of physicians, nurses, other healthcare providers, community groups, and others who provide community-based care post-discharge. The success of the pilot in reducing avoidable rehospitalizations led to statewide expansion of the project in 2010.

- ix. Consider the effects of implementation of the Affordable Care Act of 2010 and population trends on scope of practice and core competency definitions among health professions.
 1. Demand for healthcare services (500,000 to 750,000 persons newly insured in Michigan starting in 2014) and efforts to contain the costs of healthcare will have the effect of progressively shifting performance of healthcare assessments and treatments down the healthcare hierarchy of credentials and payment levels.
 - a. For example, the implementation of Accountable Care Organizations (ACOs) may present both opportunities and challenges for RNs and APRNs, depending upon federal ACO definitions and reimbursement policies.
 2. Ambiguity in the scope of practice for health professions may be tacitly encouraged by the systemic stresses of high demand for services and lower levels of reimbursement for those services.
 3. The balance between specificity and flexibility in the scope of practice and core competency definitions may be difficult to maintain under these conditions. Consider mechanisms for adjustment as needed.
4. **During this time of demographic, economic, and healthcare change, many national initiatives, laws, and standards are attempting to guide healthcare and health professions through the flux and into the future. Michigan nurses must participate in these efforts, be active, and have a strong voice in national and state forums articulating nursing's future.**
 - a. As national efforts to structure change are disseminated, Michigan nurses should bring this information into the evolution of healthcare and nursing in Michigan. The CDC publication *Healthy People 2020* should be integrated into TFNP decision-making and recommendations.¹³ The RWJF-IOM Future of Nursing initiative has major recommendations relating to the functioning of all nurses at the levels needed to provide care to their patients; this central theme also should be part of the TFNP deliberations and recommendations.¹⁴
 - b. Within the framework of the identified practice concerns of Michigan nursing, it is important to bring Michigan nursing practice into alignment with the significant changes occurring in other states and the nation.
 - i. Consider the example of those states in which Governors have opted out of Medicare/Medicaid supervisory rules/regulations with respect to APRNs and CRNAs, thus expanding the scope of practice of these health professionals and access to care for their residents.¹⁵
 - c. Consider a TFNP recommendation to establish a “successor body” for the TFNP with the tasks of overseeing implementation of TFNP recommendations, working in tandem with national nursing initiatives, and carrying these efforts into the future.
 - d. Engage in a collaborative manner with the Michigan Board of Nursing to review initiatives feasible and useful in Michigan as well as issues relevant to current and future regulation of nurses in the state.

- 5. Healthcare technology (the constantly changing and expanding array of devices used in health assessment, treatment choice, treatment implementation, and recovery/rehabilitation) and Health Information Technology (electronic medical record, practice management, decision support, and patient education) must be integrated into the practice of all health professionals and the patients and communities they serve.**
- a. In the future, the provision of high quality, safe healthcare to patients will be dependent upon the integration of technology into practice in ways that potentiate and transform care. Technology should supplement the clinical judgment of healthcare professionals, not replace that judgment.¹⁶
 - b. Nurses must take a strong role in the delineation of healthcare information systems and the implementation of those systems into practice. Healthcare information systems must be developed in a manner that supports the evolved role of nursing and the evolved role of patients as members of healthcare teams. See 5.f.ii.
 - c. Implementation of the Patient Protection & Affordable Care Act is expected to provide positive conditions for the creation of multiple Accountable Care Organizations (ACOs); the definition of an ACO awaits the promulgation of regulations from DHHS, but current examples are largely vertically integrated entities (i.e., including providers from community-based primary care to acute care) who assume capitated responsibility for the healthcare of a defined population. The role of APRNs in ACOs has not been elucidated, and currently APRNs are not included in ACO plans or draft regulations. See item 3a-ix-1a. This may constitute restraint of trade, and is unfair to APRNs.
 - d. Health Information Technology (see below) is an emerging and major factor in the healthcare environment. Incentives were provided in the American Recovery and Reinvestment Act for physician practices to invest in “meaningful use” of Electronic Medical Records to make more efficient, safe use of patient health information. There are no incentives in place to support APRN use of this technology.
 - e. The national and regional organizations setting up, writing specifications for, and implementing health information technologies and systems must recruit healthcare professionals (nurses, physicians, and allied health professions) to participate in these activities. Otherwise, HIT systems at all levels will fail to reach their goals and their promise will not be realized; the nonproductive burden on healthcare professionals will be increased for no gain in healthcare quality and safety. [Review the KFF – Ascension study of nursing and technology.]
 - i. An interdisciplinary discussion of HIT should be initiated to deal with practice/HIT issues common to healthcare professions. Experience and training in the supportive use and integration into practice of HIT is needed across the spectrum of healthcare professions and practice settings.
 - ii. Acceptance issues with respect to HIT and healthcare technology must also be addressed. There are positives/negatives in full acceptance and engagement in use of IT, since some healthcare professionals may be reluctant to learn to use IT, while others are immersed in it. The importance of IT in healthcare quality and safety is extensively discussed in QSEN materials and in *Educating Nurses*¹⁷
 - f. Nurses must have voice and take a strong role in the specification and integration of new healthcare technologies in healthcare provider systems. Otherwise, healthcare

technology will continue to consume inordinate amounts of nursing time and energy at little gain to the care of patients.

- i. Consider the development of HIT nurses and their placement in IT departments as the voice of nursing in IT development and implementation; such HIT nurses would serve as the interface between IT specialists and nursing departments. Improvement of the knowledge base of both nursing and HIT specialists is reinforced by the AHA's inclusion of Electronic Medical Record competency in their standards for hospital-based APRNs.
 - ii. Consider the difficulty of synchronizing nursing patient-care workflow and the requirements of hospital record systems. Nurses must have flexibility to handle the changing needs of patients; however, this means that it is not always possible to immediately post to a patient's computerized chart the nursing services provided, or to provide the service at the time preprogrammed into the charting computer. Charting systems often are cumbersome, requiring multiple actions to reach the specific field where data is entered, and a nurse may not have the time until the end of the shift to perform chart entries. Since chart entries are date/time stamped with the time they were entered, not the time they were performed, and the charting computer clock often is at variance with other clocks in the hospital, as well as wristwatches and cell phones, it is not surprising that records are not synchronized. Disciplinary actions have been entered against nurses because there was a discrepancy between the time entered for performance of an action and the date/time stamp attached to the chart entry; or a mismatch between the pre-programmed time and actual time a service was performed. Nurses must be engaged and empowered at every stage of EMR, charting, and IT system development so that nursing patient care is safe, high-quality, and without barriers.
 - iii. Consider the utilization of Health IT in community-based hospice operations; this venue is emerging as an environment in which IT and communications technology may play major and positive nursing roles. [Information to come from P. Miller.]
 - iv. Nurses often perform the function of interface between units of healthcare technology. When new technologies are added to an existing set of technologies, the interface often does not function well; nurses then become the means of translating the output of one testing machine into the input of another. This is a diversion of nursing time that could otherwise be spent at the bedside; this issue needs to be addressed at the industry level and the system level.¹⁸
- g. Ambulatory care settings and community care settings may provide appropriate venues to demonstrate the effective use and value of healthcare technologies and HIT. Healthcare technology already includes "Telebuddy" systems for compiling health assessment information at a distance and transmitting it to a care coordination nurse for review and response. The Veterans Administration performs care coordination using such technology; an on-line nursing care coordination fee-based service recently went into operation in Minnesota¹⁹. Nurses should support and participate in the development of initiatives to implement and test the applications of healthcare technology and HIT in community settings.

6. Workplace factors strongly impact the environment for nursing care and therefore impact the quality and safety of patient care.²⁰

- a. Workplace changes needed (see *Nursing Agenda for Michigan*):
 - i. Promote safe working hours to improve both patient and nurse safety and nurse retention.
 - ii. Improve the organization and design of nursing tasks to make them more efficient and effective.

- iii. Improve the ergonomics of nursing tasks to improve the health and safety of patients and nurses.
 - iv. Increase team approaches and shared decision-making to improve nursing input to patient care and safety
 - v. Create a more respectful and supportive nursing workplace to improve retention of the existing nursing workforce and improve retention of new nurses.
 - vi. Increase workplace mentoring and other supports to improve nurse retention.
 - vii. Identify areas for nursing task expansion and nursing task delegation to improve appropriate and efficient patient care and nursing practice.
 - viii. Improve the status of nursing by strengthening the link between revenue and nursing services.
- b. Workplace systemic changes needed (see *Nursing Agenda for Michigan*):
- i. Improve nurse retention and patient care and safety through improved work design and work environment changes.
 - ii. Improve nursing retention and patient care and safety through improved workplace and nursing career supports.
 - iii. Improve organizational cultures to improve quality and safety of care and the nursing environment (i.e., Magnet Hospitals and similar initiatives).
 - iv. Use mentors and support for career and role development to improve nurse retention (i.e., residency programs, career ladders).
 - v. Set up collaborative interprofessional teams assess patients, consider treatment options, make shared decisions, and manage and deliver patient care.
 - vi. Either build-out nursing services of varying intensity and expertise as billable hours, or merge all health professional service fees into the bundled cost of an episode of care.
 - vii. Implement national-standard health information technology systems in such a way that they improve efficiency, quality of care, and nursing satisfaction.

This draft Organizational Framework is based on TFNP Design Group and TFNP discussions and resource documents.

¹ National Council of State Boards of Nursing (NCSBN), Association of Social Work Boards, Federation of State Boards of Physical Therapy, Federation of State Medical Boards, National Association of Boards of Pharmacy, & National Board for Certification in Occupational Therapy, eds. *Changes in health care professions' scope of practice: Legislative considerations*. Chicago: 2006.

² Tool A: We propose a thought experiment: Get on a virtual gurney and go from one hospital department to another, visiting them all. Keep track of who (profession and credentials) performs what assessments and treatments, who supervises them, and how this varies from department to department. How does this compare with the ideal situation described in Principle 1? Tool B: Repeat the thought experiment in community settings: Compare community settings and the providers encountered with the hospital setting. Which setting has the most rational allocation of professional resources? Which setting most nearly accomplishes Principle 1?

³ See the work of Dr. Mary Naylor, University of Pennsylvania, with respect to patient decision-making during periods of transition.

⁴ The Veteran's Administration has issued an RFP for five centers receiving grants to redesign care so that patient decision-making is central to the care process. The Robert Wood Johnson Foundation recently issued an RFP for improvement of health literacy and support of patient engagement in their healthcare. These initiatives complement the health literacy/patient engagement provisions of the Affordable Care Act of 2010.

⁵ See relevant sections of Public Health Code: 333.16109 Definitions, 333.16215 Delegation; Board of Medicine Rules R 338.2304, & 2305 Delegation; Board of Nursing Rules R 338.10104.

⁶ *Final Report of the MDCH Task Force on Nursing Regulation*, p.21. See www.michigan.gov/mdch/ocne.

⁷ *Consensus Report on Advanced Practice Nursing*. National Council of State Boards of Nursing, 2008.

⁸ American Nurses Association (2010). *Nursing: Scope and Standards of Practice, 2nd Edition*. (pgs. 9-11).

⁹ *Quality & Safety in the Education of Nurses*. See QSEN project website: www.qsen.org.

¹⁰ On November 1, 2010, the Robert Wood Johnson Foundation announced the award of \$1.6 Million to institutions in California, Illinois, Indiana and Pennsylvania to fund initiatives testing programs aimed at eliminating racial and ethnic disparities in care.

¹¹ See the Robert Wood Johnson Foundation *Initiative on Health Quality and Equality*; www.rwjf.org/qualityequality.

¹² See www.aarp.org/ppi.

¹³ See U.S. Department of Health & Human Services, Centers for Disease Control. *Healthy People 2020*. <http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf>

¹⁴ *The Future of Nursing: Leading Change, Advancing Health*. (2010). Institute of Medicine and Robert Wood Johnson Foundation.

¹⁵ Dulisse, B and Cromwell, J. (2010). No Harm Found When Nurse Anesthetists Work Without Supervision By Physicians. *Health Affairs*, 29, no.8: 1469-1475. See <http://content.healthaffairs.org/content/29/8/1469.full.html>.

¹⁶ Benner P, Sutpen M, Leonard V, & Day L. *Educating Nurses*, Carnegie Foundation for the Advancement of Teaching, 2010. Information technology and simulation technology are suggested as a major tool in the development of nursing clinical judgment and improved transition to practice.

¹⁷ *Quality & Safety in the Education of Nurses*. See QSEN project website: www.qsen.org and Benner P, Sutpen M, Leonard V, & Day L. *Educating Nurses*, Carnegie Foundation for the Advancement of Teaching, 2010. Information technology and simulation technology are suggested as a major tool in the development of nursing clinical judgment and improved transition to practice.

¹⁸ See end notes position paper #8.

¹⁹ "HealthPartners Unveils Online Diagnostic Tool for Common Ailments", *Minneapolis Star Tribune*, 10/25/2010.

²⁰ *The Nursing Agenda for Michigan* includes many recommendations for improvements in nursing practice and nursing workplaces, with the goal of protecting and improving the health and safety of nurses, since the health and safety of patients is inextricably tied to that of the nurses serving them. Review these workforce issues for inclusion in the TFNP Final Report, since few have been directly addressed in Michigan. *The Nursing Agenda for Michigan, 2005-2010*. Published by the Coalition of Michigan Organizations of Nursing (COMON) and the MDCH Office of the Chief Nurse Executive, 2006. See www.michigan.gov/mdch/ocne; www.micom.org, and www.michigancenterfornursing.org.

This page intentionally left blank.

Crosswalk: Comparing National Standards with the Michigan Public Health Code

Background

- The American healthcare system is evolving under the pressure of economic, demographic, technological, and legislative forces.
- The US population is growing older; in Michigan almost 100,000 people per year become eligible for Medicare and increase their demand for healthcare; this pattern will continue for the next 20 years.
- Changes in the healthcare system and health insurance are expected to result in 1,500,000 Michigan residents becoming insured.
- The US population is becoming more diverse, leading to a need for healthcare professionals from diverse groups.
- Healthcare needs are becoming more complex, due to multiple chronic conditions in our aging population.
- Healthcare technology is advancing rapidly.
- Provision of healthcare by inter-professional teams improves quality and safety, and is increasing as performance is rewarded.
- Healthcare costs have been rising at rates much higher than inflation, and must be stabilized if the healthcare system is to continue.
- Nurses are the largest category of licensed healthcare professionals; there are about 170,000 licensed nurses in Michigan.
- Nurses are the primary professional caregivers for patients.
- High-quality, diverse nurses must be available to provide patient care and fill multiple roles in the evolving healthcare system.
- Nursing practice must be considered in the light of increasing healthcare demand and healthcare system changes.
- Nursing has evolved into a profession with a distinct body of knowledge, university-based education, specialized practice, a social contract (ANA 2010), and an ethical code (ANA 2001). With this grounding, the nursing profession is concerned with the availability and accessibility of nursing care to healthcare consumers, families, communities, and populations, and seeks to ensure the integrity of nursing practice in all current and future healthcare systems. (ANA Scope & Standards of Practice 2010)

Crosswalk

This Crosswalk among a) the American Nurses Association *Scope and Standards of Nursing Practice*, b) national and Michigan nursing initiatives, and c) the Health Professions portions of the Michigan Public Health Code is intended to draw attention to areas of consonance and dissonance, as well as areas in which Michigan leads and areas in which Michigan has

challenges. The goal is to make clear the topic areas in which Michigan law and policy require changes if we are to advance nursing practice to meet the needs of the people of the state. The Crosswalk is divided into major categories addressed by some or all of the listed sources.

Crosswalk Sections

1. Professional Nursing – Definitions
2. RNs (Education, Licensure, Practice)
3. LPNs (Education, Licensure, Practice)
4. APRNs (Definitions, Education, Certification, Practice, Prescriptive Authority)
5. Transition to Practice
6. Delegation/Supervision
7. Competence/Competencies
8. Ethics and Social Contract
9. Patient-Centered Care
 - a. Quality & Safety
 - b. Evidence based practice
 - c. Nursing Leadership
 - d. Interdisciplinary Practice
10. Areas to Be Referred to the Michigan Nursing Practice Council Systems, Strengths, and Challenges
 - a. Infrastructure for Nursing policy
 - b. Regulation of Nurses and Nursing
 - c. Technology and Nursing
 - d. Nursing Supply and Demand
 - i. Nursing Demographics and Population Demographics
 - ii. Healthcare Workforce Planning
 - e. Reduction of Conflicting or Inefficient Statutes
 - i. Regulate nurses, nursing assistive personnel, and nursing functions under the MPHC Nursing section (333.172) only.
 - ii. Improve nursing practice efficiency by making patient-centered care the highest priority in all reviews of state and federal regulations.

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Professional Nursing Definitions <u>Healthcare providers.</u> Individuals with special expertise who provide healthcare services or assistance to patients. They may include nurses, physicians, psychologists, social workers, nutritionist/dietitians, and various therapists. ¹</p> <p><u>Nursing</u> is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response (to illness and injury) and advocacy in the care of individuals, families, communities, and populations. ²</p>	<p>Professional Nursing Definitions <i>Nursing's Social Policy Statement, The Essence of the Profession(2010 edition):</i></p> <ul style="list-style-type: none"> Florence Nightingale defined nursing as having "charge of the personal health of somebody...is to put the patient in the best condition for nature to act upon him." ³ Virginia Henderson (1961) defined the purpose of nursing as "to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible."⁴ The Authority for Nursing Practice for Nurses "The authority for nursing, as for other professions, is based on <u>social responsibility</u>, which in turn derives from a complex social base and a social contract."⁵ "There is a social contract between society and the profession. Under its terms, <u>society grants the professions authority over functions vital to itself and permits them considerable autonomy in the conduct of their own affairs. In return, the professions are expected to act responsibly, always mindful of the public trust. Self-regulation to assure quality and performance is at the heart of this relationship.</u> It is the authentic hallmark of the mature profession. (Donabedian, 1976) ⁵ 	<p>Professional Nursing Definitions 333.16105 Definitions: (1) <u>Health Occupation</u> means a health related vocation, calling, occupation, or employment performed by an individual whether or not the individual is licensed or registered under this article. (2) <u>Health Profession</u> means a vocation, calling, occupation, or employment performed by an individual acting pursuant to a license or registration issued under this article. ⁶</p> <p>333.172.Nursing: (a) <u>Practice of nursing</u> means the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability. (b) <u>Practice of nursing</u> as a licensed practical nurse or "l.p.n." means the practice of nursing based on less comprehensive knowledge and skill than that required of a registered professional nurse and performed under the supervision of a registered professional nurse, physician, or dentist. (c) <u>Registered professional nurse</u> or "r.n." means an individual licensed under this article to engage in the practice of nursing which scope of practice includes the teaching, direction, and supervision of less skilled personnel in the performance of delegated nursing activities. ⁷</p>

Crosswalk End Notes Section 1 Definitions:

¹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice*. 2nd Edition. Silver Spring, MD (p.65.)

² *Ibid.* (p.1)

³ *Ibid.* (p.9)

⁴ *Ibid.* (p.10)

⁵ *Ibid.* (p.5)

⁶ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008. Print. 2007/2008 Legislative Session. (p.55)

⁷ *Ibid.* (pgs. 123, 124)

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Registered Nurses (Education, Licensure, Practice) Education <u>The registered nurse is educationally prepared for competent practice at the beginning level upon graduation from an accredited school of nursing and qualified by national examination for RN licensure....</u>The registered nurse is educated in the art and science of nursing , with the goal of helping individuals and groups attain, maintain, and restore health whenever possible. Experienced nurses may become proficient in one or more practice areas or roles. ... Credentialing is one form of acknowledging such specialized knowledge and experience in specialty practice. Registered nurses may pursue advanced academic studies to prepare for specialization in practice. Education requirements vary by specialty and educational program. New models for educational preparation are evolving in response to the changing healthcare, education, and regulatory practice environments. ¹. As the nurse of the future evolves, so must nursing education. Curricula must be designed to adequately prepare competent entry-level nurses. The nurse shortage and program capacity limits demand efficient educational processes. Online, virtual, simulated, and competency-based learning are attempts to expand opportunities to students and increase efficiency. However, design should be based on evidence more than tradition so that the nurse graduate is prepared to provide safe and competent care. Nursing as a profession continues to face dilemmas in entry into practice, the autonomy of advanced practice, continued competence, multistate licensure, and the appropriate educational credentials for professional certification. Registered nurses have a professional responsibility to maintain competence in their area of practice....²</p>	<p>Registered Nurses (Education, Licensure, Practice) Education Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.⁸ Higher percentages of BSN-RNs are supported by national policy recommendations, research, and the requirements of <i>Magnet</i> hospital status. BSN degrees also are required by nursing education programs seeking nurses eligible to serve as clinical faculty, and nurses seeking graduate study and/or career mobility and longevity. Alignment between nursing education programs at different levels is essential to support advancement to the BSN degree.⁹ To ensure the delivery of safe, patient-centered care across settings, the nursing education system must be improved.¹⁰ Simulations have potential for efficiently educating faculty on new technology and clinical modalities. Funding will be sought for expansion of simulation modalities, with emphasis on faculty and nurse development. Limit federal funding for nursing education programs to only those programs in states that have adopted NCSB N's Model Nursing Practice Act and Model Nursing Administrative Rules ¹¹</p> <p>Improving Nursing Education at the Program Level: "1. Come to agreement about a set of clinically relevant prerequisites. 2. Require the BSN for entry to practice. 3. Develop local articulation programs to ensure a smooth, timely transition from the AND to the BSN. 4. Develop more ADN to MSN programs. 5. Recruit a more diverse faculty and student body. 6. Provide more financial aid, whether from public or private sources, for all students, at all levels. 7. Introduce pre-nursing students to nursing early in their education. 8. Broaden the clinical experience. 9. Preserve post-clinical conferences and small patient-care assignments.</p>	<p>Registered Nurses (Education, Licensure, Practice) Education 333.16148; Sec. 16148. (1) Except as provided in section 17060, only a board may promulgate rules to establish standards for the education and training of individuals to be licensed or registered, or whose licenses or registrations are to be renewed, for the purposes of determining whether graduates of a training program have the knowledge and skills requisite for practice of a health profession or use of a title. Sec. 16148. (2) Except as provided in section 17060 and subject to subsection (6) <u>only a board may accredit training programs in hospitals, schools, colleges, universities, and institutions</u> offering training programs meeting established standards... Sec. 16148. (6) The requirement of rule 305(2)(b)(iii), being R 338.10305 of the Michigan administrative code, that each member of the nursing faculty in a program of nursing education <u>for registered nurses who provides instruction in the clinical laboratory or cooperating agencies hold a Baccalaureate degree in nursing science</u> does not apply to a member of the nursing faculty described in this subsection who meets both of the following requirements: (a) Was employed by or under contract to a program of nursing education on or before September 1, 1989. (b) Is employed by or under contract to a program of nursing education on the effective date of the amendatory act that added this subsection.¹⁷</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Licensure The registered nurse is licensed and authorized by a state, commonwealth, or territory to practice nursing. Professional licensure of the healthcare professions is established by each jurisdiction to protect the public safety and authorize the practice of the profession. Because of this, the requirements for RN licensure and advanced practice nursing vary widely.</p> <p>Registered Nurse (RN) An individual registered or licensed by a state, commonwealth, territory, government, or other regulatory body to practice as a registered nurse.³</p>	<p>10. Develop pedagogies that keep students focused on the patient's experience. 11. Vary the means of assessing student performance. 12. Promote and support learning the skills of inquiry and research 13. Redesign the ethics curricula. 14. Support students in becoming agents of change. 15. Fully support ongoing faculty development for all who educate student nurses."¹²</p> <p>Licensure Licensing and practice rules vary across states, the regulations regarding scope-of-practice – which defines the activities that a qualified nurse may perform- have varying effects on different types of nurses in different parts of the country.¹³</p> <p>See Appendix C Relationships between Nursing Education and Licensure.¹⁴</p>	<p>Licensure 333.16103 (2) "<u>Certificate of licensure</u> means a document issued as evidence of authorization to use a designated title." 333.16106(2) "License, except as otherwise provided in this subsection, means <u>an authorization issued under this article to practice where practice would otherwise be unlawful</u>. License includes an authorization to use a designated title which use would otherwise be prohibited under this article and may be used to refer to a health profession subfield license, limited license, or a temporary license."¹⁸</p> <p>333.16125. Licensing board; membership; sec.16125. A licensing board shall be composed of a majority of members licensed in the health profession which that board licenses....If a certified health profession specialty field task force is created by this article, 1 member of the board holding a license other than a health profession subfield license shall also be appointed to the specialty field task force.¹⁹</p> <p>333.16145 <u>Board or task force; official seal; rules; Sec. 1645.</u> (3) Only a board or task force shall promulgate rules to specify requirements for licenses, registrations, renewals, examinations, and required passing scores.</p> <p>333.16146 Board; granting license or registration... (2) A board which grants licenses may: (a) Certify licensees in those health profession specialty fields within its scope of practice which are established in this article. (b)</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Practice The Standards of Professional Nursing Practice are <u>authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently.</u> The standards published herein may be utilized as evidence of the standard of care, with the understanding that application of the standards is context dependent. The standards are subject to change with the dynamics of the nursing profession, as new patterns of professional practice are developed and accepted by the nursing profession and the public. In addition, specific conditions and clinical circumstances may also affect the application of the standards at a given time, e.g., during a natural disaster. The standards are subject to formal, periodic review and revision.⁴</p> <p>The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently....⁵</p> <p><u>Standards of Professional Nursing Practice.</u></p> <p>The Standards of Professional Nursing Practice content consists of the Standards of Practice and the Standards of Professional Performance....</p> <p><u>Standards of Practice:</u></p> <ul style="list-style-type: none"> • Standard 1. Assessment • Standard 2. Diagnosis • Standard 3. Outcome Identification • Standard 4. Planning • Standard 5. Implementation • Standard 5A. Coordination of Care • Standard 5B. Health Teaching and Health Promotion. • Standard 5C.Consultation • Standard 5D. Prescriptive Authority and treatment. • Standard 6. Evaluation 	<p>Practice Reform scope of practice regulations to conform to the NCSBN Model Nursing Practice Act and Model Nursing Administrative Rules (Article XVIII, Chapter 18).¹⁵</p>	<p>Reclassify licenses on the basis of a determination that the addition or removal of conditions or restrictions is appropriate.²⁰</p> <p>Practice Part 172. Nursing 333.17201 Definitions; principles of construction. Sec. 17201. (1) As used in this part: (a) <u>Practice of nursing</u> means the systematic application of substantial specialized knowledge and skill, derived from the biological, physical, and behavioral sciences, to the care, treatment, counsel, and health teaching if individuals who are experiencing changes in the normal health processes or who require assistance in the maintenance of health and the prevention or management of illness, injury, or disability.²¹</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p><u>Standards of Professional Performance:</u></p> <ul style="list-style-type: none"> • Standard 7. Ethics • Standard 8. Education • Standard 9. Evidence-Based Practice and Research. • Standard 10. Quality of Practice • Standard 11. Communication • Standard 12. Leadership • Standard 13. Collaboration • Standard 14. Professional Practice Evaluation. • Standard 15. Resource Utilization • Standard 16. Environmental Health⁶ <p>“...Registered nurses have a professional responsibility to maintain competence in their area of practice....”⁷</p>	<p><u>Standards of Professional Performance</u></p> <p>2.2.1 Standards Related to Registered Nurse (RN) Professional Accountability</p> <p>The RN:</p> <ul style="list-style-type: none"> a. Practices within the legal boundaries for nursing through the scope of practice authorized in the Nurse Practice Act (NPA) and rules governing nursing. b. Demonstrates honesty and integrity in nursing practice. c. Bases professional decisions on nursing knowledge and skills, the needs of clients and the expectations delineated in professional standards. d. Accepts responsibility for judgments, individual nursing actions, competence, decisions and behavior in the course of nursing practice. e. Maintains continued competence through ongoing learning and application of knowledge in the client’s interest. <p>***The first two standards reflect the need for any professional to accept responsibility for knowing the legal, ethical, and professional parameters of practice, maintaining those boundaries and acknowledging when a decision or action has not been in the best interest of a client while taking corrective action in the client’s behalf.¹⁶</p>	<p><u>Standards of Professional Performance:</u></p> <p>Occupational Regulation Sections of the Michigan Public Health Code are silent on standards of Professional Performance.</p>

Crosswalk Section 2 RNs End Notes:

¹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice, 2nd Edition*. Silver Spring, MD (pgs.14,15)

² *Ibid.* (p.28)

³ *Ibid.* (p.67)

⁴ *Ibid.* (See page 87 for information of this review and revision process.)

⁵ *Ibid.* (p.31)

⁶ *Ibid.* (p. 9-11.)

⁷ *Ibid.* (p.28)

⁸ The Institute of Medicine and Robert Wood Johnson Foundation. (2010). *The Future of Nursing Leading Change, Advancing Health*. (pgs. 9-11)

⁹ Final Report and Recommendations of the MDCH Task Force on Nursing Education, 2009. (pgs.12, 13.)

¹⁰ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹¹ *Ibid.*

¹² Benner et.al; Educating Nurses A call for Radical Transformation; The Carnegie Foundation for the Advancement of Teaching. 2010 (pgs.216 to 223)

¹³ Report Brief October 2010, IOM, "The Future of Nursing Leading Change, Advancing Health." (p.2)

¹⁴ Final Report and Recommendations of the MDCH Task Force on Nursing Education, 2009. (p77,78)

¹⁵ Report Brief October 2010, IOM, "The Future of Nursing Leading Change, Advancing Health." (p.2)

¹⁶ National Council of State Boards of Nursing (2010). *Model Nursing Practice Act and Model Nursing Administrative Rules*. (p.4)

¹⁷ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008. Print. 2007/2008 Legislative Session. (p.61)

¹⁸ *Ibid.* (p.55)

¹⁹ *Ibid.* (p.58)

²⁰ *Ibid.* (pgs.60. 61)

²¹ *Ibid.* (p.123)

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Licensed Practical Nurses (Education, Licensure, Practice)</p> <p>Education ANA Scope and Standards of Nursing Practice are silent on the education of practical nurses.</p> <p>Licensure ANA Scope and Standards of Nursing Practice are silent on the licensure of practical nurses.</p>	<p>Licensed Practical Nurses (Education, Licensure, Practice)</p> <p>Education In 2008, the Michigan Task Force on Nursing Education distributed a short survey through the Michigan Organization of Nurse Executives to assess trends in hiring and utilization of LPNs in hospitals. The analysis and conclusions of the survey report include the following statements:</p> <ul style="list-style-type: none"> • LPNs are decreasing as a percentage of licensed nursing staff in Michigan hospitals/systems, and are likely to decrease further. • Systems that include long term care facilities preferentially site their LPN staff in those facilities. • Nurse executives in Michigan generally see RNs as more appropriate to high-acuity settings and more flexible than LPNs in care venues with high-acuity patient populations. • The need for PN students to receive clinical education experiences in high-acuity patient settings such as Pediatrics, Obstetrics, and Emergency Departments is declining. • Nursing education should seek more practice-relevant clinical experiences for PN students in ambulatory care, coordination of care, gerontology, and pharmacology.¹ <p>Licensure Article VI. Licensure Section 1. Examinations.</p> <ol style="list-style-type: none"> a. The BON shall authorize the administration of the examination to applicants for licensure as RNs or LPN/VNs. b. The BON may employ, contract and cooperate with any entity in the preparation and process for determining results of a uniform licensure examination. When such an examination is utilized, the BON shall restrict access to questions and answers. c. The BON shall determine whether a licensure examination may be repeated, the frequency of reexamination and any requisite education prior to reexamination.² 	<p>Licensed Practical Nurses (Education, Licensure, Practice)</p> <p>Education 333.17201 Sec.17201(c) <u>Registered professional nurse</u> or “r.n.” means an individual licensed under this article to engage in the practice of nursing which <u>scope of practice includes the teaching direction, and supervision of less skilled personnel in the performance of delegated nursing activities.</u>p.123</p> <p>Sec. 16148. (7) The requirement of rule 305(2)(c)(ii), being R338.10305 of the Michigan administrative code, that each member of the nursing <u>faculty in a program of nursing education for licensed practical nurses</u> hold a baccalaureate degree in nursing science does not apply to a member of the nursing faculty described in the subsection who meets both of the following requirements :</p> <ol style="list-style-type: none"> (a) Was employed by or under contract to a program of nursing education on or before September 1, 1989. (b) Was employed by or under contract to a program of nursing education on the effective date of the amendatory act that added this subsection.⁴ <p>Licensure 333.16105 (5) “ <u>Health profession subfield</u> means an area of practice established under this article which is within the scope of the activities, functions, and duties of a licensed health profession, and requires less comprehensive knowledge and skill than is required to practice the full scope of the health profession. (LPN)⁵</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Practice ANA Scope and Standards of Nursing Practice are silent on the practice of practical nurses.</p>	<p>Practice Section 3. Licensed Practical/Vocational Nurse (LPN/VN). Practice as an LPN/VN means a directed scope of nursing practice, with or without compensation or personal profit, under the supervision of an RN, advanced practice registered nurse (APRN), licensed physician or other health care provider authorized by the state; is guided by nursing standards established or recognized by the BON; and includes, but is not limited to:</p> <ul style="list-style-type: none"> a. Collecting data and conducting focused nursing assessments of the health status of individuals. *** A focused assessment is an appraisal of an individual's status and situation at hand, contributing to comprehensive assessment by the RN, supporting ongoing data collection and deciding who needs to be informed of the information and when to inform. b. Planning nursing care episodes for individuals with stable conditions. c. Participating in the development and modification of the comprehensive plan of care for all types of clients. d. Implementing appropriate aspects of the strategy of care within a client centered health care plan. e. Communicating and collaborating with other health care professionals. f. Providing input into the development of policies and procedures. g. Other acts that require education and training as prescribed by the BON, commensurate with the LPN/VN's experience, continuing education and demonstrated LPN/VN competencies. <p>Each nurse is accountable to clients, the nursing profession and the BON for complying with the requirements of this Act and for ensuring the quality of nursing care rendered; for recognizing limits of knowledge and experience; and for planning for the management of situations beyond the nurse's expertise.</p> <p>***Additions to the LPN/VN scope of practice are based on analysis of the various elements that make up this scope as evidenced by the most recent LPN/VN job analysis. This remains a directed scope of practice.³</p>	<p>Practice 333.17201Sec. 17201 (b) Practice of nursing as a licensed practical nurse or "l.p.n." means the practice of nursing based on less comprehensive knowledge and skill than that required of a registered professional nurse and performed under the supervision of a registered professional nurse, physician, or dentist.⁶</p>

Crosswalk Section 3 LPNs End Notes:

¹ Michigan Department of Community Health- Task Force on Nursing Education. (2009). *TFNE Final Report and Recommendations*. p. 75

² National Council of State Boards of Nursing. (2011). *Model Nursing Practice Act and Model Nursing Administrative Rules*. P.24

³ Ibid. (p.8)

⁴ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code.

Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008. Print. 2007/2008 Legislative Session. (p.61)

⁵ Ibid. (p.56)

⁶ Ibid. (p.123)

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Advanced Practice Registered Nurses Definitions</p> <p><u>Advanced practice registered nurses (APRN).</u> A nurse who has completed an accredited graduate-level education program preparing her or him for the role of certified nurse practitioner, certified registered nurse anesthetist, certified nurse-midwife, or clinical nurse specialist; has passed a national certification examination that measures the APRN role and population-focused competencies; maintains continued competence as evidenced by recertification; and is licensed to practice as an APRN.¹</p>	<p>Advanced Practice Registered Nurses Definitions</p> <p>States with restrictive regulations should be urged to amend them to allow APRNs to provide care to patients in all circumstances that they are qualified to do so.⁵ An advanced practice registered nurse (APRN) is a nurse:</p> <ol style="list-style-type: none"> 1. "...Completed an accredited graduate-level education program 2. ...Passed a national certification examination..." 3. "...Acquired advanced clinical knowledge and skills preparing him/her to provide direct care to patients..." 4. "...Practice builds on the competencies of registered nurses (RNs)..." 5. "...educationally prepared to assume responsibility and accountability..." 6. "...clinical experience of sufficient depth and breadth..." 7. ...obtained a license to practice as an APRN in one of the four APRN roles: <ul style="list-style-type: none"> • Certified Registered Nurse Anesthetist (CRNA) • Certified Nurse-Midwife (CNM) • Clinical Nurse Specialist (CNS) • Certified Nurse Practitioner (CNP)⁶ <p>"LACE:" The four essential elements of APRN regulation</p> <ol style="list-style-type: none"> 1. Licensure is the granting of authority to practice. 2. Accreditation is the formal review and approval by a recognized agency of educational degree or certification programs in nursing or nursing-related programs. 3. Certification is the formal recognition of the knowledge, skills, and experience demonstrated by the achievement of standards that are identified by the profession. 4. Education is the formal preparation of APRNs in graduate degree-granting or post-graduate certificate programs... <p>APRNs specialties</p> <p>Preparation in a specialty practice – which is optional-represents a much more focused area of preparation and practice than does the APRN role. The <i>Recognition as a Nursing Specialty</i> and includes areas such as palliative care, substance abuse, nephrology, an Adult-</p>	<p>Advanced Practice Registered Nurses Definitions</p> <p>333.16105 (3) "<u>Health profession specialty field</u> means an area of practice established under this article that is within the scope of activities, functions, and duties of a licensed health profession and that requires advanced education and training beyond that required for initial licensure.</p> <p>333.16105 (4) " Health profession specialty field license means an authorization to use a title issued to a licensee who has met qualifications established by the Michigan board of dentistry for registration in a health profession specialty field, ... the <u>health profession specialty field license is not a license as that term is defined in section 16106(2).</u>¹⁷</p> <p>Part 170. Medicine</p> <p>333.17001 Definitions;</p> <p>(B) "As used in this subparagraph, "medical education" means the education of physicians and candidates for degrees or licenses to become physicians, including, but not limited to, physician staff, residents, interns, and medical students."</p> <p>333.17011 License or authorization required; granting license to individuals meeting certain requirements; prohibition; conditions for granting license; use of words, titles</p> <p>Section 17011. (1) An individual shall not engage in the practice of medicine or practice as a physician's assistant unless licensed or otherwise authorized by this article. An individual shall not engage in teaching or research that requires the practice of medicine unless the individual is licensed or otherwise authorized by this article. (2) Notwithstanding section 16145 or rules promulgated under that section the board may grant a license to an individual who meets the requirements of section 16186 or 17031(2) after reviewing the applicant's record of practice, experience, and credentials and determining that the applicant is competent to practice medicine....</p> <p>(5) Except as otherwise provided in this subsection, the following words, titles, or letters or a combination thereof, with or without qualifying words or phrases, are restricted in use only to those individuals authorized under this part to use the</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>APRN Licensure See paragraph above.</p> <p>APRN Practice <u>Competencies for the Advanced Practice Registered Nurse:</u></p>	<p>Gerontology CNS could specialize in palliative care; a CRNA could specialize in pain management; or a CNM could specialize in care of the post-menopausal woman. State licensing boards will not regulate the APRN at the level of specialties. Professional certification in the specialty area of practice is strongly recommended.</p> <p>Emergence of new APR roles and population foci As nursing practice evolves and health care needs of the population-foci may evolve over time. Therefore, the Consensus Model spells out characteristics of a process to be used to develop nationally recognized core competencies, and education and practice standards for a newly emerging role or population-focus, and a set of criteria which must be recognized.”⁷</p> <p>APRN Licensure NCSBN APRN Consensus: “Licensure and the APRN Credential under the Consensus Model: “...The APRN Consensus Model requirements call for the board of nursing to be the regulatory body that issues licenses and provides oversight of APRNs. The requirements further specify that all APRNs will be educated, certified, and licensed in one of four roles and in at least one of six population foci. But all are given the protected licensing title of Advanced Practice Registered Nurse (APRN). Education, certification, and licensure of an individual must be congruent in terms of role and population foci. APRNs may specialize but they cannot be licensed solely within a specialty area, specialties can provide depth in ones practice within the established population foci. APRNs may also decide to choose a specialty to add to the level of care they can offer within their chosen population. Competence at the specialty level will not be assessed or regulated by boards of nursing but rather by professional organizations.”⁸</p> <p>APRN Practice Licensing and practice rules vary across states, the regulations regarding scope-of-practice – which defines</p>	<p>terms and in a way prescribed in this part: “doctor of medicine”, “M.D.”, “physician’s assistant”, and “pa”. Notwithstanding section 16261, and individual who was specially trained at an institution of higher education in this state to assist a physician in the field of orthopedics and, upon completion of training, received a 2-year associate of science degree as an orthopedic physician’s assistant before January 1, 1977 may use the title “orthopedic physician’s assistant” whether or not the individual is licensed under this part.”¹⁸</p> <p>APRN Licensure 333.16106(2) License, except as otherwise provided in this subsection, means <u>an authorization issued under this article to practice where practice would otherwise be unlawful</u>. License includes an authorization to use a designated title which use would otherwise be prohibited under this article and may be used to refer to a health profession subfield license, limited license, or a temporary license. For purposes of the definition of prescriber contained in section 17708 (2) only, license includes an authorization issued under the laws of another state, or the country of Canada to practice in that state or in the country of Canada, where practice would otherwise be unlawful, and is limited to a licensed doctor of medicine, a licensed doctor of osteopathic medicine and surgery, or another licensed health professional acting under the delegation and using, recording, or otherwise indicating the name of the delegating licensed doctor of medicine or licensed doctor of osteopathic medicine and surgery. <u>License does not include a health profession specialty field license</u>. 333.1608; R Sec. 106108 (2) Registration <u>means an authorization only for the use of a designated title which use would otherwise be prohibited under this article</u>. Registration includes specialty certification of a licensee and a health profession specialty field license.”¹⁹</p> <p>APRN Practice Part 170. Medicine 333.17048 Limitation on number of physician’s</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>The advanced practice registered nurse:</p> <ul style="list-style-type: none"> • Prescribes evidence-based treatments, therapies, and procedures considering the healthcare consumer's comprehensive healthcare needs. • Prescribes pharmacologic agents based on current knowledge of pharmacology and physiology. • Prescribes specific pharmacological agents or treatments according to clinical indicators, the healthcare consumer's status and needs, and the results of diagnostic and laboratory tests. • Evaluates therapeutic and potential adverse effects of pharmacological and non-pharmacological treatments. • Provides healthcare consumers with information about intended effects and potential adverse effects of proposed prescriptive therapies. • Provides information about cost and alternative treatments and procedures, as appropriate. • Evaluates and incorporates complementary and alternative therapy into education and practice.² <p>Additional competencies for the graduate-level prepared specialty nurse and the APRN:</p> <p>The graduate-level prepared specialty nurse or the advanced practice registered nurse:</p> <ul style="list-style-type: none"> • Participates in inter-professional teams that address ethical risks, benefits, and outcomes. • Provides information on the risks, benefits, and outcomes of healthcare regimens to allow informed decision-making by the healthcare consumer, including informed consent and informed refusal.³ 	<p>the activities that a qualified nurse may perform- have varying effects on different types of nurses in different parts of the country.</p> <p><u>"Consequently, the tasks nurse practitioners are allowed to perform are determined not by their education and training, but by the unique state laws under which they work."</u>⁹</p> <p>Amend Medicare program to authorize APRN to perform admission assessments as well as certification of patients for home health care services and admission to hospice and skilled nursing facilities.¹⁰</p> <p>Expand Medicare program to include coverage of APRN services that are within scope of practice under applicable state law – only physician services are now covered.¹¹</p> <p>Extend increase in Medicaid reimbursement rates for primary care physicians included in the ACA to APRNs providing similar primary care services.¹²</p> <p>Assumptions related to Scope of Practice</p> <p>"In attempting to provide a framework for scope of practice decisions, basic assumptions can be made:</p> <ol style="list-style-type: none"> 1. The purpose of regulation –public protection—should have top priority in scope of practice decisions, rather than professional self-interest. 2. Changes in scope of practice are inherent in our current healthcare system. 3. Collaboration between healthcare providers should be the professional norm. 4. Overlap among professions is necessary. 5. Practice acts should require licensees to demonstrate that they have the requisite training and competence to provide a service."¹³ <p>Michigan Center for Nursing</p> <p>Survey of Advanced Practice Nurses 2010:</p> <p>"Characteristics of Nurse Practitioners</p> <ul style="list-style-type: none"> • Approximately 4 percent of nurse practitioners hold a Doctor of Nursing Practice degree, 3percent hold a Doctor of Philosophy degree, and less than 1 percent holds a Doctor of Nursing degree, Doctor of Nursing Science degree, or doctorate in another field. • About 96 percent of nurse practitioners hold a national certification as a nurse practitioner, 7 	<p>assistants supervised; prohibiting or restricting delegation of medical care service or requiring higher levels of supervision; delegation of ultimate responsibility prohibited; rules as to drugs; ordering, receiving, and dispensing complimentary starter dose drugs.</p> <p>Sect.17048 (5) The board may promulgate rules for the delegation by a supervising physician to a physician's assistant of the function of prescription of drugs.</p> <p>(6) A supervising physician may delegate in writing to a physician's assistant the ordering, receipt, and dispensing of complimentary starter dose drugs other than controlled substances as defined by article 7 or federal law.</p> <p>333.17049 Responsibilities of physician supervising physician's assistant. (6) <u>Notwithstanding any law or rule to the contrary, a physician is not required to countersign orders written in a patient's clinical record by a physician's assistant to whom the physician has delegated the performance of medical care services for a patient.</u></p> <p>333.17076 Medical care services by physician's assistant; supervision required; exception; medical care setting required; making calls or going on rounds; prescribing drugs; indicating name of supervising physician; ordering, receiving, and dispensing complimentary starter dose drugs.²⁰</p> <p>333.16109 Sec. 16109. (1) <u>Specialty certification</u> means an authorization to use a title by a licensee who has met qualifications established by a board for registration in a health profession specialty field.</p> <p>333.16109 Sec. 16109. (2) <u>Supervision</u>, except as otherwise provided in this article, means the overseeing of or participation in the work of another individual by a health professional licensed under this article in circumstances where at least <u>all of the following conditions exist:</u></p> <ol style="list-style-type: none"> (a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional. (b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
	<p>percent hold a national certification as a clinical nurse specialist, and 1percent hold a national certification as a nurse midwife.</p> <ul style="list-style-type: none"> • The length of time that nurse practitioners have practiced <i>as a nurse practitioner</i> ranges from less than one year to more than 35 years, with the bulk of nurse practitioners (49 percent) having 6 to 15 years of practice experience in their principal advanced practice capacity. • Almost all nurse practitioners (99 percent) are involved in providing direct patient care services in their advanced practice capacity. This compares to 83 percent of all active RNs licensed in Michigan who provide direct patient care services in their main nursing position. • About 50 percent of nurse practitioners spend more than 35 hours per week providing direct patient care. Another 13 percent spend 31-35 hours per week providing direct patient care. • About 39 percent of nurse practitioners report that their main practice area is in a category that could be considered primary care, that is, family practice (19.0 percent) Internal medicine (10.4 percent) and pediatrics (9.5 percent). An additional 8.7percent report their main practice area is women's health..."¹⁴ <p>Article XVIII. APRN Scope of Nursing Practice Section</p> <p>1. Practice of APRNs. Advanced practice registered nursing by certified nurse practitioners (CNP), certified registered nurse anesthetists (CRNA), certified nurse midwives (CNM) or clinical nurse specialists (CNS) is based on knowledge and skills acquired in basic nursing education; licensure as an RN; and graduation from or completion of a graduate level APRN program accredited by a national accrediting body and current certification by a national certifying body in the appropriate APRN role and at least one population focus.¹⁵</p>	<p>to further educate the supervised individual in the performance of the individual's functions.</p> <p>(c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.</p> <p>333.16111. (3) A part in this article does not prohibit a licensee under another part or other law of this state from performing activities and using designated titles authorized by a license issued to him or her under that other part or other law of this state.</p> <p>333.16125. Licensing board; membership; sec.16125. A licensing board shall be composed of a majority of members licensed in the health profession which that board licenses....If a certified health profession specialty field task force is created by this article, 1 member of the board holding a license other than a health profession subfield license shall also be appointed to the specialty field task force.</p> <p>333.16128 Sec. 16128 (2) A health profession specialty field task force shall be composed of a majority of members registered in the specialty fields of the health profession that are created by this article.²¹</p> <p>333.16174 Sec. 16174. (1) An individual who is licensed or registered under this article shall meet all of the following requirements:</p> <p>(a) Be 18 or more years old.</p> <p>(b) Be of good moral character</p> <p>(c) Have a specific education or experience in the health profession or in a health profession subfield or health profession specialty field of the health profession, or training equivalent, or both, as prescribed by this health profession specialty field of the health profession, or training equivalent, or both, as prescribed by this health profession specialty field of the health profession, or training equivalent, or both, as prescribed by this article or rules of a board necessary to promote safe and competent practice and informed consumer choice. ...²²</p> <p>333.16175 License or registration; minimum standards of educational prerequisites, Sec.16175. In developing minimum standards of educational prerequisites for licensure or registration, a board and its task forces shall consider equivalency and proficiency testing and other mechanisms, ...and other training, education, or</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Prescriptive Authority Standard 5D <u>Prescriptive Authority</u> and Treatment: The advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.⁴</p>	<p>Prescriptive Authority Practice as an APRN means an expanded scope of nursing in a role and population focus approved by the BON, with or without compensation or personal profit, and includes the RN scope of practice. <u>The scope of an APRN includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing and ordering. APRNs may serve as primary care providers of record.</u> APRNs are expected to practice as licensed independent practitioners within standards established and/or recognized by the BON. Each APRN is accountable to patients, the nursing profession and the BON for complying with the requirements of this Act and the quality of advanced nursing care rendered; for recognizing limits of knowledge and experience; planning for the management of situations beyond the APRN's expertise; and for consulting with or referring patients to other health care providers as appropriate.¹⁶</p>	<p>experience which may provide equivalence to completion of formal educational requirements.²³</p> <p>333.16178 Examinations, investigations, or evaluations to determine qualifications of applicants; passing national or regional examination; reexamination; notice of examination or evaluation. Sect16178.(1) Unless otherwise necessary for a board to fulfill national or regional testing requirements, the department shall conduct examinations or other evaluations necessary to determine qualifications of applicants for initial licensure or registration at least annually and may conduct other investigations or evaluations necessary to determine the qualifications of applicants. A board may accept passing a national or regional examination developed for use in the United States for the purpose of meeting a state board examination or a part thereof....²⁴</p> <p>Prescriptive Authority 333.7105 (3): "<u>Dispense</u> means to deliver or issue a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a practitioner, including the prescribing, administering, or compounding necessary to prepare the substance for the delivery or issuance." 333.7105 (4): "<u>Dispenser</u> means a practitioner who dispenses." 333.7109 (3): "<u>Practitioner</u> means: (a) A prescriber or pharmacist, a scientific investigator as defined by rule of the administrator, or <u>other person</u> licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state..." (b.) "A pharmacy, hospital, or other institution or place of professional practice licensed, registered, or otherwise permitted to distribute, prescribe, dispense, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state." 333.7109 (4): "<u>Prescriber</u> means that term as defined in section 17708"²⁵</p> <p>Part 177. Pharmacy Practice and Drug Control 333.17708 Definitions (2) "<u>Prescriber</u>" means a licensed dentist, a licensed</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
		<p>doctor of medicine, a licensed doctor of osteopathic medicine and surgery.</p> <p>(3) "<u>Prescription</u>" means an order for a drug or device written and signed or transmitted by facsimile, electronic transmission, or other means of communication by a prescriber to be filled, compounded, or dispensed...²⁶</p>

Crosswalk Section 4 APRNs End Notes:

¹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition. Silver Spring, MD: Nursesbooks.org; (p.63)

² *Ibid.* (p.44)

³ *Ibid.* (p.48)

⁴ *Ibid.* (p.44)

⁵ The Institute of Medicine and Robert Wood Johnson Foundation. (2011). *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press. (p.278)

⁶ National Council of State Boards of Nursing. Campaign for APRN Consensus, Definition of APRN. Retrieved at www.ncsbn.org/aprn.

⁷ *Ibid.*

⁸ *Ibid.*

⁹ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹⁰ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹¹ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹² The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹³ National Council of State Boards of Nursing. (2006). *Changes in Healthcare Professions' Scope of Practice: Legislative Consideration*. Retrieved from <https://www.ncsbn.org/Scopeofpractice.pdf>

¹⁴ Michigan Center for Nursing. (2010). *Survey of Advanced Practice Registered Nurses*. Retrieved at http://www.michigancenterfornursing.org/mimages/2010apn_survey.pdf

¹⁵ National Council of State Boards of Nursing. (2011). *Model Nursing Practice Act and Model Nursing Administrative Rules*. p.91.

¹⁶ *Ibid*

¹⁷ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008.Print. 2007/2008 Legislative Session. (pgs.55, 56)

¹⁸ *Ibid.* (pgs.108-109)

¹⁹ *Ibid.* (pgs. 56- 57)

²⁰ *Ibid.* (pgs. 119- 122)

²¹ *Ibid.* (pgs. 56- 58)

²² *Ibid.* (p.64)

²³ *Ibid.* (p.65)

²⁴ *Ibid.* (p.66)

²⁵ *Ibid.* (pgs. 10- 12)

²⁶ *Ibid.* (p. 141)

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Transition to Practice ANA Scope and Standards of Nursing Practice are silent on Transition to Practice.</p>	<p>Transition to Practice “The goal of NCSBN’s Transition to Practice Model is to promote public safety by supporting newly licensed nurses during their critical entry period and progression into practice¹ Guiding Principles</p> <ul style="list-style-type: none"> ▪ The mission of boards of nursing (BON’S) is to protect public health, safety and welfare. ▪ Nursing regulators recognize the value of evidence-based models in their responsibility of public protection. ▪ Transitioning new nurses to practice is best accomplished when practice, education and regulation collaborate. ▪ Transition to practice programs should occur across all settings and education levels. ▪ Regulation criteria for transition programs should reflect minimum requirements and be the least burdensome criteria consistent with public protection. ▪ Transition program outcomes are consistent with knowledge, skills and attitudes required for safe and effective provision of nursing care. <p><u>Definition – Transition to Practice:</u> A formal program of active learning implemented across all settings, for newly licensed nurses (registered nurses (RNs) and licensed practical/vocational nurses (LPN/LVNs) designed to support their progression from education to practice.²</p> <p>“High turnover rates among new nurses underscore the importance of transition-to-practice residency programs, which help manage the transition from nursing school to practice and help new graduates further develop the skills needed to deliver safe, quality care. While nurse residency programs sometimes are supported in hospitals and large health systems, they focus primarily on acute care. However, residency programs need to be developed and evaluated in community settings.”³</p> <p>Standard 8: Nationally fund the development and implementation of nurse residency programs across all practice settings to keep current with healthcare technology, information systems, and expectations for nursing care.⁴</p>	<p>Transition to Practice Occupation Regulations Sections of the Michigan Public Health Code are silent on Transition to Practice.</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
	<p>MDCH – Task Force on Nursing Education: NEPP 3: Nurse Residency Programs Required in Michigan for Newly Licensed Graduates of All Nursing Education Programs.⁵</p> <p><i>Michigan Nursing Education Council(MNEC): Transition to Practice Committee is developing an Outline of Core Objectives for Transition to Practice Residency Programs(based on NCSBN model)</i></p> <p>IOM Recommendation 3: Implement nurse residency programs. State boards of nursing, accrediting bodies, the federal government, and health care organizations should take actions to support nurses’ completion of a transition-to-practice program (nurse residency) after they have completed a pre-licensure or advanced practice degree program or when they are transitioning into new clinical practice areas.⁶</p>	

Crosswalk Section 5 Transition End Notes:

¹ National Council of State Boards of Nursing. *Transition to Practice Toolkit*. Retrieved from <https://www.ncsbn.org/1603.htm>

² *Ibid.*

³ The Institute of Medicine and Robert Wood Johnson Foundation (2010). *The Future of Nursing Leading Change, Advancing Health*.

⁴ *Ibid.*

⁵ Michigan Department of Community Health-Task Force on Nursing Practice. (2008). *TFNE Final Report*. (pgs. 19-21)

⁶ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Delegation/Supervision Delegation: “The transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome. Example: the RN, in delegating a task to an assistive individual, transfers the responsibility for the performance of the task but retains professional accountability for the overall care.”¹</p>	<p>Delegation/Supervision ANA has developed a document called: “Principles for Delegation” – This document is designed to provide overarching principles and guidelines for practice in situations where registered nurses delegate tasks to others. “The American Nurses Association (ANA) recognizes that there is a clear distinction between RN and licensed practical/vocational nurse (LPN/LVN) practice.”²</p> <p><u>Definition- Delegation:</u> “The transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome. Example: the RN, in delegating a task to an assistive individual, transfers the responsibility for the performance of the task but retains professional accountability for the overall care, Principles of Delegation³</p> <p><u>Definition- Supervision:</u> “The active process of directing, guiding and influencing the outcome of an individual’s performance of a task. Supervision is generally categorized as on-site (the RN being physically present or immediately available while the task is being performed) or off-site (the RN has the ability to provide direction through various means of written and verbal communications). Individuals engaging in supervision of patient care should not be construed to be managerial supervisors on behalf of the employer.”⁴</p> <p>Policy Statements:</p> <ul style="list-style-type: none"> ▪ “The RN takes responsibility and accountability for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse’s obligation to provide optimum patient care.”^{5 6} ▪ All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety and welfare of the public.⁷ <p>Nurse-related Principles:</p> <ul style="list-style-type: none"> ▪ The RN may delegate elements of care but does not delegate the nursing process itself. ▪ The RN has the duty to answer for personal actions relating to the nursing process. 	<p>Delegation/Supervision 333.16104 (1) “<u>Delegation</u> means an authorization granted by a licensee to a licensed or unlicensed individual to perform selected acts, tasks, or functions that fall within the scope of practice of the delegator and that are not within the scope of practice of the delegatee and that, in the absence of the authorization, would constitute illegal practice of a licensed profession.”¹¹</p> <p>333.16109 Sec. 16109. (2) <u>Supervision</u>, except as otherwise provided in this article, means the overseeing of or participation in the work of another individual by a health professional licensed under this article in circumstances where at least <u>all of the following conditions exist:</u></p> <p>(a) The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional.</p> <p>(b) The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual in the performance of the individual’s functions.</p> <p>(c) The provision by the licensed supervising health professional of predetermined procedures and drug protocol.¹²</p> <p>Sec. 16111. (3) A part in this article does not prohibit a licensee under another part or other law of this state from performing activities and using designated titles authorized by a license issued to him or her under that other part or other law of this state.¹³</p> <p>333.16215 Delegation of acts, tasks, or functions to licensed or unlicensed individual; supervision; rules; immunity; third party reimbursement or worker’s compensation benefits Sec.16215. (1) Subject to subsections (2) to (6), a licensee who holds a license other than a health profession subfield license may delegate to a licensed or unlicensed individual who is otherwise qualified by education, training or experience the performance of selected acts, tasks, or functions where the acts, tasks,</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
	<ul style="list-style-type: none"> ▪ The RN takes into account the knowledge and skills of any individual to whom the RN may delegate elements of care. ▪ The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated. Principles of Delegation p.5 • The RN uses critical thinking and professional judgment when following <i>The Five Rights of Delegation</i>: <ul style="list-style-type: none"> Right task Right circumstances Right person Right directions and Communication Right supervision and evaluation⁸ <p>MDCH – Task Force on Nursing Regulation NRPP 5.2: Delegation of Nursing Tasks It is recommended that the Director of MDCH charge the 2008 Task Force on Nursing Education and Task Force on Nursing Practice with a substantive review of the content and implementation of Michigan statutes and rules governing the delegation of nursing tasks. The PHC and MBON Rules define nursing delegation and supervision and provide guidelines; however, <i>de facto</i> administration and practice may place nurses, their licenses, and their patients in jeopardy. Specific issues related to Long Term Care (LTC) include workplace conflicts and stresses that will worsen as the nursing shortage increases. Knowledge and understanding of delegation as a continuum of nursing processes is needed, as is the will to put patient safety before economic expediency. Education on delegation for nursing students (as part of curriculum), nurses (as a component of license renewal), nursing home administrators (as a component of license renewal), and nursing home regulators should be included in recommended solutions, in addition to potential statute and rules revisions.⁹</p> <p>See Position Paper 3 <i>Clarifying Delegation of Nursing Functions</i>.</p> <p>2.2.4 Standards Related to RN Responsibility to</p>	<p>or functions fall within the scope of practice of the licensee's profession and will be performed under the licensee's supervision. A licensee shall not delegate an act, task, or function under this section if the act, task, or function, under standards of acceptable and prevailing practice, requires the level of education, skill, and judgment required of the licensee under this article...¹⁴</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
	<p>Organize, Manage and Supervise the Practice of Nursing</p> <p>The RN:</p> <ul style="list-style-type: none"> a. Assigns to another only those nursing measures that fall within that nurse's scope of practice, education, experience and competence or unlicensed person's role description. b. Delegates to another only those nursing measures for which that person has the necessary skills and competence to accomplish safely. c. Matches client needs with personnel qualifications, available resources and appropriate supervision. d. Communicates directions and expectations for completion of the delegated activity. e. Supervises others to whom nursing activities are delegated or assigned by monitoring performance, progress and outcomes; and assures documentation of the activity. f. Provides follow-up on problems and intervenes when needed. g. Evaluates the effectiveness of the delegation or assignment. h. Intervenes when problems are identified and revises plan of care as needed. i. Retains professional accountability for nursing care as provided.¹⁰ 	

Crosswalk Section 6 Delegation End Notes:

¹ American Nurses Association (2010). Nursing: Scope and Standards of Practice, 2nd Edition. Silver Spring, MD: Nursesbooks.org; (p.64)

² ANA American Nurses Association. (2005). *Principals of Delegation*. Silver Spring, Maryland.

³ *Ibid.* (p.4)

⁴ *Ibid.* (p.4)

⁵ American Nurses Association (2010). *Guide to the Code of Ethics for Nurses Interpretation and Application*. Silver Spring, MD. p.41

⁶ American Nurses Association. (2010). *Principals of Delegation*. p.6.

⁷ *Ibid.* (p.5)

⁸ *Ibid.* (p.5)

⁹ Michigan Department of Community Health-Task Force on Nursing Regulation. (2008). *TFNR Final Report*.

¹⁰ National Council of State Boards of Nursing. (2011). *Model Nursing Practice Act and Model Nursing Administrative Rules*.

¹¹ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008.Print. 2007/2008 Legislative Session. (p.55)

¹² *Ibid.* (p.57)

¹³ *Ibid.* (p.57)

¹⁴ *Ibid.* (p.75)

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Competence/Competencies <u>Competency.</u> An expected and measureable level of nursing performance that integrates knowledge, skills, abilities, and judgment, based on established scientific knowledge and expectations for nursing practice.¹</p>	<p>Competence/Competencies <u>Competence/Competency</u> “Definitions and Concepts in Competence”</p> <ul style="list-style-type: none"> • An individual who demonstrates “<u>competence</u>” is performing successfully at an expected level. • A “<u>competency</u>” is an expected level of performance that integrates knowledge, skills, abilities, and judgment. • The integration of knowledge, skills, abilities, and judgment occurs in formal, informal, and reflective learning experiences. • Knowledge encompasses thinking; understanding of science and humanities; professional standards of practice, and insights gained from practical experiences, personal capabilities, and leadership performance. • Skills include psychomotor, communication, interpersonal, and diagnostic skills. • Ability is the capacity to act effectively. It requires listening integrity, knowledge of one’s strengths and weaknesses, positive self-regard, emotional intelligence, and openness to feedback. • Judgment includes critical thinking, problem solving, ethical reasoning, and decision-making. • Formal learning most often occurs in structured, academic, and professional development environments, while informal learning can be described as experiential insights gained in work, community, home, and other settings. Reflective learning represents the recurrent thoughtful personal self-assessment, analysis, and synthesis of strengths and opportunities for improvement. Such insights should lead to the creation of a specific plan for professional development and may become part of one’s professional portfolio.”⁵ <p>Summary of Other Organizations Statements on Competence: The Institute of Medicine (IOM)...”identified five areas of competence for all health care providers: <u>patient-centered care, interdisciplinary team, evidence-based practice, quality improvement and informatics</u>⁶ These IOM areas of competence have been expanded and articulated for nursing through the Quality and Safety Education for Nurses project⁷ The National Council of State Boards of Nursing (NCSBN) defines competence as “the application of knowledge and the interpersonal, decision-making and</p>	<p>Competence/Competencies <u>Competency.</u> CEU Requirements and Pain Management Article 15. Occupations Part 161. General Provisions</p> <p>333.16106 Sec. 16106. (1)“<u>Incompetence</u>” means a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs.¹⁶</p> <p>333.16204 <u>Completion of continuing education</u> as condition for license renewal; completion of hours or courses in pain and symptom management; rules; certain individuals excluded. 333.16204a <u>Advisory committee on pain</u> and symptom management; creation; members; compensation; expenses; terms; duties; review of guidelines. 333.16204b. Treatment of Pain; enactment of legislation. Sec. 16204b. The legislature finds that the treatment of pain is an appropriate issue for the legislature to consider, and that the citizens of this state would be well served by the enactment of legislation that accomplishes all of the following: (a) Provides more and better information to health care consumers regarding the medical treatment of pain... (b) Provides for the appointment of an advisory body to study and make recommendations on model core curricula on pain and symptom management... (c) Educates health professionals about the disciplinary process for state licensees and registrants... 333.16204c Medical treatment of pain; use of controlled substances; legislative findings; treatment by licensed health professionals; electronic monitoring system; “controlled substance” defined. 333.16204d Information booklet on pain; development by department of consumer and industry services; educational program for health professionals. 333.16205 <u>Attendance at educational programs as condition to license renewal; waiver; rules for assessing continued competence</u> Sec. 16205. (1) A Board which requires evidence of attendance at educational programs as a condition to</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p><u>Scope of Nursing Practice.</u> The description of the, “who, what, where, when, why, and how” of nursing practice that addresses the range of nursing practice activities common to all registered nurses. When considered in conjunction with the Standards of Professional Nursing Practice² and the <u>Code of Ethics for Nurses</u>, [“A list of provisions that makes explicit the primary goals, values, and obligations of the nursing profession and expresses its values, duties, and</p>	<p>psychomotor skills expected for the practice role, within the context of public health, safety and welfare” NCSBN holds that continued competence is a critical regulatory issue for Boards of Nursing.⁸</p> <p>The American Association of Critical Care Nurses (AACN) Synergy Model for patient care identifies nurse competencies of concern to patients, clinical units and systems. The core concept of the AACN Synergy Model is that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. These competencies include: <u>clinical judgment, advocacy and moral agency, caring practices, collaboration, systems thinking, response to diversity, facilitation of learning, and clinical inquiry</u> (AACN, 1999)⁹</p> <p>Joint Commission on Accreditation of Healthcare Organizations (JCAHO): According to the Joint Commission (2007) “competence assessment is systematic and allows for a measurable assessment of the person’s ability to perform required activities. Information used as part of competence assessment may include data from performance evaluations, performance improvement, and aggregate data on competence, as well as the assessment of learning needs” p.346.¹⁰</p> <p>The Competency and Credentialing Institute (2007) convened a think tank of nursing leaders to build consensus for a process of continued competence for professional nurses that is practical, cost-effective, transferable, and a nationally accepted platform in order to ensure patient safety and quality of care for the public. Competency is valued as central to practice and will require a revamping of educational practices, information literacy, interdisciplinary teams and learning and is influenced by policy.^{11 12}</p> <p><u>Scope of Nursing Practice: Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.</u> Being a partner involves taking responsibility for identifying problems and areas of system waste, devising and implementing improvement plans, and tracking improvement over time, and making necessary adjustments to realize established goals.¹³</p> <p><u>“Nurses should practice to the full extent of their</u></p>	<p>license renewal may waive those requirements if, upon written application, the board finds the failure of the licensee to attend was due to the licensee’s disability, military service, absence from the continental United States, or a circumstance beyond the control of the licensee which the board considers good and sufficient.</p> <p>(2) A board may promulgate rules to establish a system of assessing the continued competence of licensees as a condition of periodic license renewal.¹⁷</p> <p><u>Scope of Nursing Practice.</u> Occupational Regulation Sections of the Michigan Public Health Code are silent on Scope of Nursing Practice competency.</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>commitments to the society of which it is a part. In the United States, nurses abide by and adhere to the Code of Ethics for Nurses³, which comprehensively describes the competent level of nursing common to all registered nurses.⁴</p>	<p><u>education & training.”¹⁴</u></p> <p>NCSBN Definitions related to Competence:</p> <ol style="list-style-type: none"> 1. Competence - The application of knowledge, and the interpersonal, decision-making and psychomotor skills expected for the practice role within the context of public health, safety and welfare. 2. Competence assessment - Evaluation of the practitioner’s knowledge, skills and abilities. Assessment mechanisms may include examination, peer review, professional portfolio and professional certification. 3. Competence conduct - The health and behavior expectations that may be evaluated through reports from the individual practitioner, employer reports and discipline checks. Part of competence conduct is assurance that licensees possess the functional abilities to perform the essential functions of the nursing role and population focus. 4. Competence development - The method by which a practitioner gains, maintains or refines practice knowledge, skills and abilities. This development can occur through formal education program, continuing education or clinical practice and is expected to continue throughout one’s career.¹⁵ 	

Crosswalk Section 7 Competence End Notes:

¹ American Nurses Association (2010). Nursing: Scope and Standards of Practice, 2nd Edition. Silver Spring, MD (p.64)

² *Ibid.* (pgs. 9-13)

³ American Nurses Association (2010). *Guide to the Code of Ethics for Nurses Interpretation and Application*. Silver Spring, MD. p.55

⁴ *Ibid.* (pgs. 55-70)

⁵ American Nurses Association. (2008). Position Statement: Professional Role Competence. *Congress of Nursing Practice and Economics*. pgs. 3-4.

⁶ The Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press, Washington, DC. Retrieved from <http://iom.edu/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>

⁷ Cronenwett, Sherwood, Barnsteiner, et.al. (2007) Quality and Safety Education for Nurses Project.

⁸ National Council of State Boards of Nursing. (1996) Retrieved from <https://www.ncsbn.org/1325.htm>

⁹ American Association of Critical-Care Nurses. (2008). *AACN Scope and Standards for Acute and Critical Care Nursing Practice*. Retrieved from http://www.aacn.org/WD/Practice/Docs/130300-Standards_for_Acute_and_Critical_Care_Nursing.pdf

¹⁰ http://www.jointcommission.org/standards_information/standards.aspx

¹¹ <http://cc-institute.org/home>

¹² Congress of Nursing Practice and Economics, *op cit.*

¹³ The Institute of Medicine and Robert Wood Johnson Foundation. (2010). *The Future of Nursing Leading Change, Advancing Health*.

¹⁴ *Ibid.* (p.2)

¹⁵ National Council of State Boards of Nursing. (2011). *Model Nursing Practice Act and Model Nursing Administrative Rules*. p.12.

¹⁶ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008.Print. 2007/2008 Legislative Session. (p.56)

¹⁷ *Ibid.* p.73

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p><i>Ethics and Social Contract</i> <u>Standards of Professional Performance</u> Standard 7. Ethics: The registered nurse practices ethically. Competencies: The registered nurse:</p> <ul style="list-style-type: none"> • Uses Code of Ethics for Nurses with Interpretive Statements (ANA, 2001) to guide practice. • Delivers care in a manner that preserves and protects healthcare consumer autonomy, dignity, rights, values, and beliefs. • Recognizes the centrality of the healthcare consumer and family as core members of any healthcare team. • Upholds healthcare consumer confidentiality within legal and regulatory parameters. • Assists healthcare consumers in self determination and informed decision-making. • Maintains a therapeutic and professional healthcare consumer-nurse relationship within appropriate professional role boundaries.¹ 	<p><i>Ethics and Social Contract</i> <u>Standards of Professional Performance</u> Standard 7. Ethics: Code of Ethics for Nurses with Interpretive Statements:</p> <ol style="list-style-type: none"> 1. The nurse in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems. <ol style="list-style-type: none"> 1. Respect for human dignity 2. Relationships to patients 3. The nature of health problems 4. The right to self-determination 5. Relationships with colleagues and others. 2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community. 3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient. <ol style="list-style-type: none"> 1. Privacy 2. Confidentiality 3. Protection of participants in research 4. Standards and review mechanisms 5. Acting on questionable practice 6. Addressing impaired practice 4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care. <ol style="list-style-type: none"> 1. Acceptance of accountability and responsibility 2. Accountability for nursing judgment and action 3. Responsibility for nursing judgment and action 4. Delegation of nursing activities 5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth. <ol style="list-style-type: none"> 1. Moral self-respect 2. Professional growth and maintenance of competence 3. Wholeness of character 4. Preservation of integrity 6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the 	<p><i>Ethics and Social Contract</i> <u>Standards of Professional Performance</u> Standard 7. Ethics: 333.16174 Sec. 16174. (1) An individual who is licensed or registered under this article shall meet all of the following requirements: (a) Be 18 yrs old. (b) <u>Be of good moral character</u> (c) Have a specific education or experience in the health profession or in a health profession subfield or health profession specialty field of the health profession, or training equivalent, or both, as prescribed by this health profession specialty field of the health profession, or training equivalent, or both, as prescribed by this health profession specialty field of the health profession, or training equivalent, or both, as prescribed by this article or rules of a board necessary to promote safe and competent practice and informed consumer choice.⁴ 16174 Sec. 16174(3) Beginning May 1, 2006 an applicant for initial licensure or registration shall submit his or her fingerprints to the department of state police to have a criminal history check conducted and request that the department of state police forward his or her fingerprints to the federal bureau of investigation for a national criminal history check.⁵</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
	<p>provision of quality health care and consistent with the values of the profession through individual and collective action.</p> <ol style="list-style-type: none"> 1. Influence of the environment on moral virtues and values 2. Influence of the environment on ethical obligations 3. Responsibility for the healthcare environment <p>7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.</p> <ol style="list-style-type: none"> 1. Advancing the profession through active involvement in nursing and in healthcare policy 2. Advancing the profession by developing, maintaining, and implementing professional standards in clinical, administrative, and education practice 3. Advancing the profession through knowledge development, dissemination, and application to practice <p>8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.</p> <ol style="list-style-type: none"> 1. Health needs and concerns 2. Responsibilities to the public <p>9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.</p> <ol style="list-style-type: none"> 1. Assertion of values 2. The profession carries out its collective responsibility through professional associations. 3. Interprofessional integrity² <p>NCSBN Definition of Cultural bias: Non-nursing elements of examination is representative of a defined body of knowledge.³</p>	

Crosswalk Section 8 Ethics End Notes:

¹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice, 2nd Edition*. Silver Spring, MD (p. 47, 48)

² American Nurses Association (2010). *Guide to the Code of Ethics for Nurses Interpretation and Application*. Silver Spring, MD. (pgs. 147 – 169)

³ National Council of State Boards of Nursing. (2011). *Model Nursing Practice Act and Model Nursing Administrative Rules*. p..12)

⁴ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008.Print. 2007/2008 Legislative Session. (p. 64)

⁵ *Ibid.* (p.65)

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>Patient Centered Care “Patient. Recipient to nursing practice. The term patient is used to provide consistency and brevity, bearing in mind that other terms such as <i>client, individual, resident, family, groups, communities, or populations</i>, might be better choices in some instances. When the patient is an individual, the focus is on the health state, problems, or needs of the individual. When the patient is a family or group, the focus is on the health state of the unit as a whole or the reciprocal effects on the individual’s health state on the other members of the unit. When the patient is a community or population, the focus is on personal and environmental health and the health risks of the community or population.”¹</p> <p>Quality & Safety Standard 10: Quality of Practice The registered nurse contributes to quality nursing practice. Competencies The registered nurse:</p> <ul style="list-style-type: none"> • Demonstrates quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner. • Uses creativity and innovation to enhance nursing care. • Participates in quality improvement. Activities may include: <ul style="list-style-type: none"> ▪ Identifying aspects of practice important for quality monitoring; ▪ Using indicators to monitor quality, safety 	<p>Patient Centered Care “Principles for Change: The challenge faced by the U.S. health care system have been described and documented in recent years by many government agencies researchers, policy analysts, and health professionals. From this work, a consensus has begun to emerge regarding some of the fundamental principles that should guide changes to meet these challenges. Broadly, the consensus is that care in the United States must become more patient centered...”⁷</p> <p><i>Crossing the Quality Chasm</i> identified patient-centered care as one of the six pillars on which a 21st-century health care system should be built (the others being safety, effectiveness, timeliness, efficiency and equity (IOM, 2001).⁸</p> <p><u>Provide Patient-Centered Care-</u> Identify, respect and care about patients’ differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision-making and management; and continuously advocate disease prevention, wellness and promotion of healthy lifestyles including a focus on population health.</p> <p><u>Work in Interdisciplinary teams-</u> Cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.⁹</p> <p>Quality & Safety <u>Apply quality improvement</u> Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality.¹⁰</p> <p><u>Quality and Safety</u> The Robert Wood Johnson Foundation (RWJF) has funded the Quality and Safety Education for Nurses (QSEN) project for three phases to date. The overall goal through all phases of QSEN is to address the challenge of preparing future nurses with the</p>	<p>Patient Centered Care Public Health Code Act 368 of 1978 An ACT to <u>protect and promote public health</u>; to codify, revise, consolidate, classify, and add to the laws relating to public health; to provide for the prevention and control of diseases and disabilities; to provide for the classification, administration, regulation, financing, and maintenance of personal, environmental, and other health services and activities; ...to promote the efficient and economical delivery of health care services, to provide for the appropriate utilization of health care facilities and services, and to provide for the closure of hospitals or consolidation of hospitals or services; to provide for the collection and use of data and information; to provide for the transfer of property; to provide certain immunity from liability; to regulate and prohibit the sale and offering for sale of drug paraphernalia under certain circumstances; to provide for the implementation of federal law; to provide for penalties and remedies; to provide for sanctions for violations of this act and local ordinances; to provide for an appropriation and supplements; to repeal certain acts and parts of acts; to repeal certain parts of this act; and to repeal certain parts of this act on specific dates.¹⁶</p> <p>Part 56A 333.5651. This part shall be known and may be cited as the “Michigan dignified death act”.¹⁷</p> <p>Quality & Safety The Occupational Regulation Sections of the Michigan Public Health Code is silent on Quality and Safety.</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>and effectiveness of nursing practice;</p> <ul style="list-style-type: none"> Collecting data to monitor quality and effectiveness of nursing practice; Analyzing quality data to identify opportunities for improving nursing practice; Formulating recommendations to improve nursing practice or outcomes; Implementing activities to enhance the quality of nursing practice; Developing, implementing, and/or evaluating policies, procedures, and guidelines to improve the quality of practice; Participating in and/or leading efforts to minimize costs and unnecessary duplication; Identifying problems that occur in day-to-day work routines in order to correct process inefficiencies;(BHE/MONE, 2006) Analyzing factors related to quality, safety, and effectiveness, Analyzing organizational systems for barriers to quality healthcare consumer outcomes; and Implementing processes to remove or weaken barriers within organizational systems. <p>Additional Competencies for the graduate-level prepared specialty nurse and the APRN.</p> <p>The graduate-level prepared specialty nurse or the advanced practice registered nurse:</p> <ul style="list-style-type: none"> Provides leadership in the design and implementation of quality improvements. Designs innovations to effect change in practice and improve health outcomes. Evaluates the practice environment and quality of nursing care rendered in relation to existing evidence. Identifies opportunities for the generation and use of research and evidence. Obtains and maintains professional certification if it is available in the area of expertise. Uses the results of quality improvement in initiate changes in nursing practice and the 	<p>knowledge, skills and attitudes (KSA) necessary to continuously improve the quality and safety of the healthcare systems in which they work.</p> <p>In order accomplish this goal; <u>six competencies were defined in Phase I of the project.</u> These competencies included five from the Institute of Medicine (IOM)-<u>patient centered care, teamwork and collaboration, evidence-based practice, quality improvement and informatics- as well as safety.</u> In addition to these definitions, sets of knowledge, skills and attitudes for each of the six competencies were created for use in nursing pre-licensure programs ¹¹</p> <p><u>Pilot schools integrated the six competencies in their nursing programs in Phase II of QSEN.</u> The pilot schools have shared their work on the QSEN website (www.qsen.org), contributing teaching and development strategies as well as other collaborative resources.</p> <p>Phase III was funded in November, 2008 and will</p> <ul style="list-style-type: none"> Continue to promote innovation in the development and evaluation of methods to elicit and assess student learning of KSA of the six IOM/QSEN competencies and the widespread sharing of these competencies. Develop faculty expertise necessary to assist the learning and assessment of achievement of quality and safety competencies in all types of nursing program. Create mechanisms to sustain the will to change among all programs through the content of textbooks, accreditation and certification standards, licensure exams and continued competence requirements.¹² 	

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>healthcare delivery system.²</p> <p>Evidence-based practice Standard 13: Research The registered nurse integrates research findings into practice. Measurement Criteria: The registered nurse:</p> <ul style="list-style-type: none"> • Utilizes the best available evidence, including research findings, to guide practice decisions. • Actively participates in research activities at various levels appropriate to the nurse's level of education and position. Such activities may include: • Identifying clinical problems specific to nursing research (patient care and nursing practice). • Participating in data collection (surveys, pilot projects, and formal studies). • Participating in a formal committee or program. • Sharing research activities and/or findings with peers and others. • Conducting research. • Critically analyzing and interpreting research for application to practice. • Using research findings in the development of policies, procedures and standards of practice in patient care. • Incorporating research as a basis for learning. <p>Additional Measurement Criteria for the Advanced Practice Registered Nurse: The advanced practice registered nurse:</p> <ul style="list-style-type: none"> • Contributes to nursing knowledge by conducting or synthesizing research that discovers, examines, and evaluates knowledge, theories, criteria, and creative approaches to improve healthcare practice. • Formally disseminates research findings through activities, such as presentations, publications, consultation, and journal clubs³ <p>Standard 9: Evidence-Based Practice and Research The registered nurse integrates evidence and research findings into practice Competencies</p>	<p>Evidence-based practice <u>Employ evidence-based practice</u> - Integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.¹³</p>	<p>Evidence-based practice The Occupational Regulation Sections of the Michigan Public Health Code is silent on Evidence-based practice.</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>The registered nurse:</p> <ul style="list-style-type: none"> Utilizes current evidence-based nursing knowledge, including research findings, to guide practice. Incorporates evidence when initiating changes in nursing practice. Participates, as appropriate to education level and position, in the formulation of evidence-based practice through research. Shares personal or third-party research findings with colleagues and peers <p>Additional Competencies for the graduate-level prepared specialty nurse and the APRN</p> <p>The graduate-level prepared specialty nurse or the advanced practice registered nurse:</p> <ul style="list-style-type: none"> Contributes to nursing knowledge by conducting or synthesizing research and other evidence that discovers, examines, and evaluates current practice, knowledge, theories, criteria, and creative approaches to improve healthcare outcomes. Promotes a climate of research and clinical inquiry. Disseminates research findings through activities such as presentations, publications, consultation, and journal clubs.⁴ <p>Nursing Leadership Standard 15: Leadership The registered nurse provides leadership in the professional practice setting and the profession Measurement Criteria: The registered nurse:</p> <ul style="list-style-type: none"> Engages in teamwork as a team player and a team builder. Works to create and maintain healthy work environments in local, regional, national, or international communities. Displays the ability to define a clear vision, the associated goals, and a plan to implement and measure progress. Demonstrates a commitment to continuous, lifelong learning for self and others. Teaches others to succeed by mentoring and other strategies. Exhibits creativity and flexibility through times of change. 	<p>Nursing Leadership “Strong leadership is critical if the vision of a transformed health care system is to be realized. Yet not all nurses begin their career with thoughts of becoming a leader. <u>The nursing profession must produce leaders throughout the health care system, from the bedside to the boardroom</u>, who can serve as full partners with other health professionals and be accountable for their own contributions to delivering high-quality care while working collaboratively with leaders from other health professions.”¹⁴</p>	<p>Nursing Leadership The Occupational Regulation Sections of the Michigan Public Health Code is silent on Nursing Leadership</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<ul style="list-style-type: none"> • Demonstrates energy, excitement, and a passion for quality work. • Willingly accepts mistakes by self and others, thereby creating a culture in which risk-taking is not only safe, but expected. • Inspires loyalty through valuing of people as the most precious asset in an organization. • Directs the coordination of care across settings and among caregivers, including oversight of licensed and unlicensed personnel in any assigned or delegated tasks. • Serves in key roles in the work setting by participating on committees, councils, and administrative teams. • Promotes advancement of the profession through participation in professional organizations.⁵ <p>Interdisciplinary Practice ANA Standard 13: Collaboration The Registered nurse collaborates with healthcare consumer, family, and others in the conduct of nursing practice. Competencies: The registered nurse:</p> <ul style="list-style-type: none"> • Partners with others to effect change and produce positive outcomes through the sharing of knowledge of the healthcare consumer and/or situation. • Communicates with the healthcare consumer, the family and healthcare providers regarding healthcare consumer care and the nurse's role in the provision of that care. • Promotes conflict management and engagement. • Participates in building consensus or resolving conflict in the context of patient care. • Applies group process and negotiation techniques with healthcare consumers and colleagues. • Adheres to standards and applicable codes of conduct that govern behavior among peers and colleagues to create a work environment that promotes cooperation, respect, and trust. • Cooperates in creating a documented plan focused on outcomes and decisions related to 	<p>Interdisciplinary Practice Key Message: Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States.</p> <p>IOM Report indicates a need for collaboration. Recommendation 2: Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. Private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices. To this end:</p> <ul style="list-style-type: none"> • The Center for Medicare and Medicaid Innovation should support the development and evaluation of models of payment and care delivery that use nurses in an expanded and leadership capacity to improve health outcomes and reduce costs. Performance measures should be developed and implemented expeditiously where best practices are evident to reflect the contributions of nurses and ensure better-quality care. • Private and public funders should collaborate, and when possible pool funds, to advance research on models of care and innovative solutions, including 	<p>Interdisciplinary Practice The Occupational Regulation Sections of the Michigan Public Health Code is silent on interdisciplinary practice.</p>

ANA Scope and Standards of Nursing Practice	National and State Initiatives	Michigan Public Health Code
<p>care and delivery of services that indicates communication with healthcare consumers, families, and others.</p> <ul style="list-style-type: none"> Engages in teamwork and team-building process. <p>Additional competencies for the graduate-level prepared specialty nurse and the APRN</p> <p>The graduate-level prepared specialty nurse or the advanced practice registered nurse:</p> <ul style="list-style-type: none"> Partners with other disciplines to enhance healthcare consumer outcomes through interprofessional activities, such as education, consultation, management, technological development, or research opportunities. Invites the contribution of the healthcare consumer, family, and team members in order to achieved optimal outcomes. Leads in establishing, improving, and sustaining collaborative relationships to achieve safe, quality healthcare consumer care. Documents plan-of-care communications, rationales for plan-of-care changes, and collaborative discussions to improve healthcare consumer outcomes.⁶ 	<p>technology, that will enable nurses to contribute to improved health and health care.</p> <ul style="list-style-type: none"> Health care organizations should support and help nurses in taking the lead in developing and adopting innovative, patient-centered care models. Health care organizations should engage nurses and other front-line staff to work with developers and manufacturers in the design, development, purchase, implementation, and evaluation of medical and health devices and health information technology products.¹⁵ 	

Crosswalk Section 9 Patient Centered Care End Notes:

¹ American Nurses Association (2010). *Nursing: Scope and Standards of Practice*, 2nd Edition. Silver Spring, MD p. 146

² *Ibid.* p. 52-53

³ *Ibid.* Appendix D.

⁴ *Ibid.* p.51

⁵ *Ibid* Appendix D

⁶ *Ibid.* p. 57-58.

⁷ The Institute of Medicine and Robert Wood Johnson Foundation. (2011). *The Future of Nursing Leading Change, Advancing Health*. The National Academies Press, Washington, DC. p.50.

⁸ *Ibid.* p.51

⁹ The Institute of Medicine. (2003). Health Professions Education: A Bridge to Quality. Retrieved from <http://www.iom.edu/Reports/2003/Health-Professions-Education-A-Bridge-to-Quality.aspx>

¹⁰ *Ibid*

¹¹ Quality and Safety Education for Nurses. *Patient Centered Care*. Retrieved from <http://www.qsen.org/definition.php?id=1>

¹² Quality and Safety Education for Nurses. Press Release April 2007. Retrieved from <http://www.qsen.org/overview.php#phase-two-press-release>

¹³ *The Institute of Medicine, op cit.*

¹⁴ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹⁵ The Institute of Medicine and Robert Wood Johnson Foundation, *op cit.*

¹⁶ Michigan Department of Community Health. Bureau of Health Professions. Occupational Regulation Sections of the Michigan Public Health Code. Articles 1, 7, 15, 19 and Excerpts from Articles 5 and 17, of Act 368 of 1978 as Amended. Lansing, Michigan: Michigan Department of Community Health Bureau of Health Professions, 2008.Print. 2007/2008 Legislative Session. (p.1)

¹⁷ *Ibid.* (pgs. 6-9)

Michigan Nursing Practice Council	Michigan Strengths & Challenges	National Strengths & Challenges
<p>TFNP Recommendations to Be Referred to the MNPC</p> <ol style="list-style-type: none"> 1. Oversight of Implementation of TFNP Recommendations 1-9. <p>Additional Areas of Concern To Be Referred to the MNPC</p> <ol style="list-style-type: none"> 1. Identify existing resources and barriers re: <ol style="list-style-type: none"> i. Infrastructure for Nursing Policy. ii. Regulation of Nurses and Nursing iii. Technology and Nursing iv. Nursing Supply and Demand v. Reduction of Conflicting or Inefficient Statutes 2. Develop strategies appropriate for these areas 3. Develop strategic partnerships 4. Develop additional resources 5. Consolidate resources to remove barriers. 6. Consider areas of concern in revised structure. 	<p>Systems Strengths and Challenges Relevant to Implementation of Recommendations 1-9</p> <ol style="list-style-type: none"> 1. Identification of Strengths and Challenges in Existing State Healthcare System. <ol style="list-style-type: none"> i. Multiple regulatory reinvention and review initiatives within State Government. ii. Recognition of demographic and economic changes and their implications for the health and safety of Michigan's people. iii. Barriers to changing existing statutes and regulations due to cultural assumptions and economic patterns. <p>Systems Strengths and Challenges Relevant to these Areas of Concern</p> <ol style="list-style-type: none"> 1. Review State resources & barriers re: <ol style="list-style-type: none"> i. Nursing Policy Infrastructure ii. Regulation of Nurses and Nursing iii. Technology and Nursing iv. Nursing Supply and Demand v. Reduction of Conflicting or Inefficient Statutes 2. Leverage existing resources & barriers 3. Leverage partnerships for mutual goals 4. Leverage additional resources 5. Consolidate position in resulting structure. 6. Repeat Steps 1-5 in revised structure. 	<p>System Strengths, and Challenges Relevant to Implementation of Recommendations 1-9</p> <ol style="list-style-type: none"> 1. Identification of Strengths and Challenges in Existing Federal Healthcare System. <ol style="list-style-type: none"> i. CMS initiative to make Medicare participation regulations for hospitals less inefficient and more flexible. ii. HRSA & DOL recognition of healthcare workforce needs and required changes in recruitment, education & practice. iii. Barriers to changing existing statutes and regulations due to cultural assumptions and economic patterns. <p>Systems Strengths and Challenges Relevant to these Areas of Concern</p> <ol style="list-style-type: none"> 1. Review national resources & barriers re: <ol style="list-style-type: none"> i. Nursing Policy Infrastructure ii. Regulation of Nurses and Nursing iii. Technology and Nursing iv. Nursing Supply and Demand v. Reduction of Conflicting or Inefficient Statutes 2. Leverage existing resources & barriers 3. Leverage partnerships for mutual goals 4. Leverage additional resources 5. Consolidate position in resulting structure. 6. Repeat Steps 1-5 in revised structure.

TFNP Information Gathered

Nursing Practice Issues Statements

The Michigan nursing community and the public have been important contributors to the work of the Task Force on Nursing Practice (TFNP), since the nursing practice issues submitted to the TFNP have served to focus the deliberations of the Task Force. The members of the TFNP express their appreciation and thanks to all those who took the time to submit nursing practice issues. Your input to the Task Force process enriched deliberations and the Final Report immeasurably.

The TFNP elicited and collected nursing practice issues in several ways. The website for the Center for Nursing Workforce & Policy included an interactive form that was used to enter and submit nursing practice issues. The webpage was publicized through the Coalition of Michigan Organizations of Nursing (COMON), and through conferences and TFNP members. The webpage “went live” in February 2011, and over 70 issue forms were submitted by members of the nursing community and the public during 2011. The nursing practice issue forms were abstracted and then grouped by issue topic. All of the issues were used to inform the discussion of TFNP Workgroups, which were formed around the major nursing practice issue groupings.

Between June 2011 and October 2011, the TFNP held five regional Nursing Practice Forums, in which over 600 Michigan nurses and members of the public participated. Nursing issues were elicited and articulated at the Forums (see overarching themes below). The Forums increased the number of issues submitted to the TFNP, and engaged members of the nursing community in urging their colleagues to go to the website and submit their issues. The processes by which issue forms were elicited and collected were successful in that the TFNP received more than double the number of issue forms submitted to the 2008 Task Force on Nursing Regulation or the 2009 Task Force on Nursing Education.

Thank you to all those who participated in the important process of nursing practice issue collection. The TFNP paid close attention to each issue submitted, and the large issue groupings represented in the 10 TFNP Recommendations and Position Papers have their foundations in the issues submitted by the nurses and people of Michigan. The nursing practice issue forms are part of the TFNP permanent archive.

Nursing Practice Regional Forums

The MDCH - TFNP was charged to examine nursing practice issues in Michigan with the goal of modernizing the nursing practice environment, thereby protecting the health and safety of the public. The TFNP identified current nursing practice issues through input from nurses, nursing organizations, and the public statewide. To encourage wide participation, the TFNP hosted a series of five forums in 2011 to hear from practicing nurses, other healthcare professionals, consumers, and other stakeholders. The Forums were held regionally in Marquette (June), Gaylord (July), Southfield (August), Grand Rapids (September), and Lansing (October).

At each Forum, TFNP members led Focus Groups, and TFNP Co-Chairs spoke about the TFNP progress to date. The Forum program included a presentation by the Michigan Chief Nurse Executive with an update on Changes in the National Health System and the effects of these changes on nurses (and vice versa). This was followed by Focus Groups led by TFNP members and staff. Each Focus Group table initially discussed a major issue topic, followed by a lively discussion of group members’ issues. The Forum meeting packet included information on the TFNP, nursing practice issues, Michigan and national nursing initiatives, national healthcare system changes of importance to nurses, and information on Michigan nursing organizations. This program carried 1.5 Continuing Education hours for each nurse attending. Total participation at all of the Forums was over 600 nurses and other stakeholders, with the highest attendance in Southeast Michigan (232), Southwest Michigan (125), and Lansing (120). Several

nursing and healthcare organizations provided meeting space or subsidized refreshments (see Acknowledgements). The effect of the Forums was seen in utilization of the TFNP webpage on www.micnwp.org and the website (www.micomon.org) of the Coalition of Michigan Organizations of Nursing; both websites had two to three times their previous traffic after the Forums began in late June. This effect persisted through March 2012, and indicates that Forum attendees became more engaged in nursing initiatives in Michigan. A report was prepared for each Forum and a study was completed of the major themes developed during the Forums. These documents are presented below.

TFNP Forum Reports

Report on TFNP Upper Peninsula Michigan Regional Forum Marquette, Michigan, June 29, 2011

On June 29, 2011, the TFNP convened its first forum in Marquette, Michigan, at the Marquette General Hospital Education Center. The event was telecast to other locations in the Upper Peninsula, permitting a total of 72 participants from hospitals, home health, mental health, clinics, and education. The Michigan Chief Nurse Executive, Jeanette Klemczak, spoke about the changing national healthcare structure and the ways in which Michigan nurses can prepare for and help shape these changes. Ms. Klemczak was joined by three members of the TFNP: Jim Fischer of Munson Medical Center, Kerri Schuiling of Northern Michigan University, and Henry Talley of Michigan State University. Following the presentation, attendees broke into six groups to discuss issues occurring in day-to-day nursing practice. Topics included: Scope of Practice in Nursing, Delegation in Nursing, Inefficiencies in Practice Settings, Health Information Technology, and Communication. See the Overarching Themes section for the content of roundtable discussions. The TFNP would like to thank the staff at Marquette General Hospital for their hospitality and assistance in making this forum successful.

Report on TFNP Northern Lower Michigan Regional Forum Gaylord, Michigan, July 19, 2011

On July 19, 2011, the TFNP convened its second forum in Gaylord, Michigan. The event exceeded expectations, with 58 nurses attending and participating. The Michigan Chief Nurse Executive, Jeanette Klemczak, spoke about the changing national healthcare structure and the ways in which Michigan nurses can prepare for and help shape these changes. Ms. Klemczak was joined by five members of the TFNP: Jim Fischer of Munson Medical Center, Patricia McCain of Saginaw Township Community Schools-School Nurse Consultant, MaryLee Pakieser of the Michigan Council of Nurse Practitioners, Carole Stacy of the Michigan Center for Nursing, and Jennifer Woods of Northern Michigan Regional Hospital. Following the presentation, attendees broke into six groups to discuss issues occurring in day-to-day nursing practice. Topics included: Scope of Practice in Nursing, Delegation in Nursing, Inefficiencies in Practice Settings, Health Information Technology, and Communication. See the Overarching Themes section for the content of roundtable discussions.

Report on TFNP Southeast Michigan Regional Forum Southfield, Michigan, August 30, 2011

On August 30, 2011, the TFNP convened its third forum in Southfield, Michigan. The event exceeded expectations, with 232 nurses attending and participating. Attendees were from diverse practice settings including, hospitals, mental health, veteran affairs, clinics, home health, health departments, and education. The Michigan Chief Nurse Executive, Jeanette Klemczak, spoke about the changing national healthcare structure and the ways in which Michigan nurses can prepare for and help shape these changes. Ms. Klemczak was joined by nine members of the TFNP: Chris Pacini of the University of Detroit Mercy, Craig Huard of the Michigan Nurse Anesthetists Association, Mary Kravutske of Henry Ford Health System, Charlotte Mather of Genesis Health System, Amy Perry of the Michigan Board of Nursing, Joanne Pohl Professor Emerita - University of Michigan School of Nursing, Erin Savelle of the Michigan Student Nurses Association, Linda Taft of the Coalition of Michigan Organizations of Nursing, and

Kathleen Vollman of the Michigan Clinical Nurse Specialists Association. Following the presentation, attendees broke into fourteen groups to discuss issues occurring in day-to-day nursing practice. Topics included: Scope of Practice in Nursing, Delegation in Nursing, Inefficiencies in Practice Settings, Health Information Technology, and Communication. See the Overarching Themes section for the content of roundtable discussions. The TFNP would like to thank the Far Eastern and American Nurses Association for their sponsorship of the refreshments for this event.

Report on TFNP Southwest Michigan Regional Forum Grand Rapids, Michigan, September 2, 2011

On September 2, 2011, the TFNP convened its fourth forum in Grand Rapids, Michigan. The event was co-sponsored by the West Michigan Nursing Advisory Council (WMNAC), Alliance for Health, and the Michigan Department of Community Health. The event included 125 nurses and members of the public attending and participating from diverse practice settings including: hospitals, clinics, home health, health departments, healthcare payers, healthcare consulting groups, and education. The Michigan Chief Nurse Executive, Jeanette Klemczak, spoke about the changing national healthcare structure and the ways in which Michigan nurses can prepare for and help shape these changes. Ms. Klemczak was joined by eight members of the TFNP: Jim Fischer of Munson Medical Center, Andrea Bostrom of Kirkhof College of Nursing at Grand Valley State University, Katie Childs of the Michigan Nursing Students Association, Deborah Leblanc from Detroit Receiving Hospital, Patrick Miller from Hospice of Michigan, Linda Scott of Kirkhof College of Nursing at Grand Valley State University, Carole Stacy of the Michigan Center for Nursing, and Teresa Wehrwein of Michigan State University College of Nursing. Following the presentation, attendees broke into twelve groups to discuss issues occurring in day-to-day nursing practice. Topics: Scope of Practice in Nursing, Delegation in Nursing, Inefficiencies in Practice Settings, Health Information Technology, and Communication. See the Overarching Themes section for the content of roundtable discussions. The TFNP wishes to thank the Alliance for Health for providing meeting space and staff assistance, and the WMNAC for their sponsorship of the refreshments for this event.

Report on TFNP Statewide Forum Lansing, Michigan, October 20, 2011

On October 20, 2011, the TFNP convened its fifth and final forum in Lansing, Michigan. 120 nurses attended and participated in the event from diverse practice settings including: hospitals, clinics, home health, health departments, mental health, business, and education. State Representative Liss attended the forum and spoke to attendees about different legislative measures that would advance nursing practice. Representative Liss is the only nurse in the legislature and was provided attendees with a unique legislative perspective. MDCH Deputy Director of Policy and Planning, Melanie Brim, followed Representative Liss' comments with remarks about the how MDCH is working to advance Michigan's nursing workforce and policy environments in partnership with the legislature and the Office of the Chief Nurse Executive. The Michigan Chief Nurse Executive, Jeanette Klemczak, gave a presentation on the changing national healthcare structure and the ways in which Michigan nurses can prepare for and help shape these changes. Ms. Klemczak was joined by eleven members of the TFNP: Chris Pacini of University Detroit Mercy, Shari Carson from NexCare Health Systems, Elizabeth Henry of Sparrow Hospital, Mary Korsgren of the Licensed Practical Nurses Association, Nancy Martin from VitalCare, Patrick Miller from Hospice of Michigan, Marie Patrick of Holt Senior Care and Rehab Center, Linda Scott of Kirkhof College of Nursing at Grand Valley State University, Carole Stacy from the Michigan Center for Nursing, Linda Taft from the Coalition of Michigan Organizations of Nursing, and Henry Talley from Michigan State University College of Nursing. Following the presentation, attendees broke into thirteen groups to discuss issues occurring in day-to-day nursing practice. Topics included: Scope of Practice in Nursing, Delegation in Nursing, Inefficiencies in Practice Settings, Health Information Technology, Communication, and Nurse Staffing. See the Overarching Themes section for the content of roundtable discussions. The TFNP would like to thank Representative Liss and Deputy Director Melanie Brim for their presentations.

Overarching Themes
TFNP Five Michigan Regional Forums
Marquette - Gaylord - Southfield - Grand Rapids – Lansing
June-October 2011

Scope of Practice

- Registered Nurses (RNs) need to know where to find a statement of their scope of practice and that of Licensed Practice Nurses (LPNs) and Nurse Assistive Personnel (NAPs).
- APRNs scope of practice and competencies must be clearly defined in the MPHIC.
- Organizational job descriptions do not equate to the scope of practice for APRNs, RNs and LPNs.

Delegation

- The scope of practice and competencies of LPNs and NAPs is often unknown, leaving RNs reluctant to delegate nursing functions: increasing workload and stress for RNs.
- Process of delegation and proper techniques need to be better taught in nursing schools. Practicing RNs also need more education on best delegation practices and how to report if delegated nursing function is preformed incorrectly.
- RNs need to understand that they are accountable for everything they delegate and must follow up with the delegatee. RNs must understand the competencies of LPNs and NAPs to responsibly delegate nursing functions to the proper individual.

Technology

- Electronic Health Records (EHRs) often do not capture nursing outcomes, as many systems provide poor options for nursing care descriptions. EHR systems also do a poor job of capturing care coordination and don't always allow for seamless transitions between care settings.
- Nurses need to be involved in every aspect of EHR development; from creation to implementation.
- Nurses often don't understand how to best integrate new EHR systems into their established workflow.

Inefficiencies

- Patient transfers between facilities are often delayed because of miscommunication and failure to appropriately transfer complete patient records.
- Nurses stated that some organizations resist adopting current, "best practices" because management is resistant to change and comfortable with how care is currently delivered.
- APRNs and RNs are not utilized to their fullest potential (full scope of practice) in care settings, often because institutions are unaware of RNs and APRNs full scope of practice, education and competencies.
- Discharge planning: from care coordination to preparing for discharge, the process needs to be revitalized to increase communication and information between all care settings.

Communication

- Generation gaps in nursing staff affect communication between staff members; the nursing community needs to focus on alleviating this friction.
- Different professional and ethnic cultures communicate differently creating conflict in RN→RN, Physician→RN, and RN→LPN communication.
- Patient handoffs often lack a completed patient record, requiring RN duplication. EHRs could help if all members of the patient care team record patient information into the EHR system.
- A better communication system is needed between all care settings including ambulatory care.
- Communication skills need to be taught in interdisciplinary teams in educational institutions, this builds mutual respect and partnerships between nurses and physicians.

Transition to Practice

- Nurse Residency programs should be included in RN educational requirements.
- The nursing profession needs to agree on how nurse residency programs will be funded.

Nurse Staffing

- Many nurses expressed concern regarding patient safety when nurses are required to fulfill mandatory overtime requests. Some nurses work two jobs and work longer than 12 hours consistently, putting additional strain on patient safety.
- Data must be analyzed to provide more evidence-based staffing models. Managing work hours should be a shared responsibility between the nurse, the employer, and the profession.

Evaluation of Forums

Nurses wishing to receive Continuing Education hours for attendance at one of the Forums were required to complete an evaluation form. The evaluation forms included 15 multiple choice questions and 4 discussion questions about the forum, with general comments invited. The 378 Forum participants who completed evaluation forms gave the Forums and the speakers a score of 89 out of 100 on the multiple choice questions about the overall program, program objectives, and the major speaker. The lowest scores were received on a question about the length of the event, with 25 - 30% of respondents stating that the length of the event should be extended. This was reinforced in the comments, many of which also indicated that this series of informational meetings should be repeated annually.

Other consistently repeated comments were that: participants would take the Forum content back to their workplace and share it with their peers and supervisors; participants found it empowering and reinforcing to find that nurses all over the state share the same practice issues; getting together to discuss issues was both fun and empowering; and participants would continue to follow nursing policy issues in the state and nation. General comments included the usual ones about the size, acoustics, and temperature of the meeting room, plus strong approval or disapproval from those with definite feelings about the event. Generally, the Forums were very positive events for the members of the Task Force and for a strong majority of the participants, with some enthusiastic participants lobbying for repeating the Forums in 2012.

This page intentionally left blank.

Appendix C – Definitions, Acronyms & Useful Websites

Definitions Used in the TFNP Final Report

Note: TFNP definitions that require changes in the Michigan Public Health Code are in italics

Advanced Practice Registered Nurse (APRN)* - *A registered nurse who holds second licensure in one of the current APRN roles [Clinical Nurse Specialist, Certified Nurse Anesthetist, Certified Nurse Midwife, and Certified Nurse Practitioner] by virtue of additional knowledge and skills gained through an advanced formal education program of nursing that has national nursing accreditation. This advanced formal education program of nursing in one of the four APRN roles shall result in a minimum of a nursing master's degree, a post-nursing-master's-degree specialty certificate, or a nursing doctorate. APRNs also must meet the certification requirements of appropriate national nursing certification bodies.*

Assignment** - The distribution of work for which each staff member is responsible during a given work period. "Assign" is used to describe those situations when a nurse directs an individual to do something the individual is already authorized to do. Once a function has been delegated to an individual, the function may be assigned to that individual for a given work period. [See definition of nursing delegation]

Care across the lifespan - The care of an individual from pre-natal care to death.

Care/work environment - Any environment in which patient care is provided (homes, long-term-care facilities, community-based clinics, hospice, and hospitals) and in which nurses work to provide patient care. The well-being of patients is inextricably linked to the well-being of the nurses caring for them.

Certified Nurse Anesthetist - *A registered nurse who holds second licensure as a Certified Nurse Anesthetist who provides the full spectrum of anesthesia care and anesthesia-related services for individuals across the lifespan and in all healthcare locations.*

Certified Nurse Midwife - *A registered nurse who holds second licensure as a Certified Nurse Midwife who provides a full range of primary care services for women throughout their lifespan, including comprehensive maternity and newborn care, and treatment of male partners for sexually transmitted infection and reproductive health.*

Certified Nurse Practitioner - *A registered nurse who is licensed as a Certified Nurse Practitioner who provides: comprehensive assessments, screening, diagnosing, treating, and managing patients with acute and chronic illnesses and diseases; health promotion; disease prevention, health education, and counseling of patients and families with potential, acute, and chronic health disorders.*

Clinical Nurse Specialist - *A registered nurse who is licensed as a Clinical Nurse Specialist who provides specialized programs of healthcare for acute and chronically ill patients and their families. Within healthcare systems, CNSs lead and direct evidence-based care and care-system-improvement programs that strengthen the quality, safety, and cost effectiveness of the healthcare provided to the public.*

Communication between delegator and delegatee *** - Must be a two-way process that permits both delegator and delegatee to ask questions and seek clarification. The exchange between the Registered Nurse (RN) delegator and the delegatee to whom responsibility for appropriate performance of the nursing function) is given requires constant evaluation, feedback, and modification to achieve the results needed to meet patient care goals. [See definition of nursing delegation]

Competence* - The application of knowledge and the interpersonal decision-making and psychomotor skills expected for the practice role within the context of public health, safety and welfare.

Education/care/work environment - Any environment in which patient care is provided. Nurses work to provide patient care and nurses receive education on how to improve this environment through appropriate management of human factors.

Electronic Health Record (EHR) - Computer software used to record/capture and store information about patient health history, conditions, treatment, outcomes, and providers.

Focused nursing assessment by an LPN - An appraisal of an individual's health status and the situation at hand, contributing to comprehensive assessment by the Registered Nurse, supporting ongoing data collection and deciding who needs to be informed of the information and when to inform.

Healthcare Technologies (HT) - *Tools that assist patient care. HT includes, but is not limited to: electronic devices that assist in patient care, electronic teaching tools, electronic monitoring systems and devices, and electronic health records, etc. Technology impacts patient care received and must support the standards of practice in all practice settings. Health Information Technology (HIT) is a tool that allows information to be accessed independently, regardless of patient or provider location, allowing individuals to communicate to benefit patient care and outcomes.*

Human factors - Aspects of being human (physical, perceptual, psychological, or behavioral) that are relevant to the system or item being analyzed. If the system or item must interface with humans, but human factors are not taken into account, the system or item will not function as intended. For example, if programming a blood pressure monitor requires that the programmer switch back and forth between pounds of pressure and kilograms of pressure, it is likely that errors will be made and the monitor will not function as intended.

Services in a learned profession - *Services rendered by a dentist, an osteopathic physician, a physician, a surgeon, a doctor of divinity or other clergy, an attorney-at-law, or registered nurse.*

Licensed Practical Nurse* (LPN) - *LPN practice is a subfield of nursing. Therefore, practice as a LPN means practice of nursing under the delegation and supervision of a Registered Nurse (RN). LPNs are responsible for their actions in the performance of delegated nursing functions, tasks and activities, while the supervising RN is accountable for the overall care and safety of the patient/client and the outcomes of nursing care.*

Licensed person - An individual who is licensed or otherwise legally authorized to practice a professional service by a court, department, board, commission, or an agency of this state or another jurisdiction. [Michigan Public Health Code]

“Meaningful Use” of Electronic Health Records - The federal definition of Meaningful Use is being rolled out in 3 stages. Stages 1 & 2 have been defined, while the remaining stage will be completed by 2015. For more detailed information on the requirements for Meaningful Use Stages 1 & 2 please see www.healthit.hhs.gov. The main components of Meaningful Use are: the use of a certified EHR in a meaningful manner, such as e-prescribing, the use of certified EHR technology for electronic exchange of health information to improve quality of health care, and the use of certified EHR technology to submit clinical quality and other measures. The definition of Meaningful Use has been updated several times and is best accessed through the federal website:

<http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2> and/or http://www.cms.gov/ehrincentiveprograms/30_Meaningful_Use.asp. [As of April 1, 2012]

Nurse - *When used without modification or amplification, means only a registered nurse. [Wisconsin State Laws]*

Nurse Aide - Any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay.

Nurse-employers - Are institutions, organizations, or individuals who employ nurses to practice nursing. Typically, nurse-employers are home-health organizations, long-term care facilities, hospices, community clinics, physician practices, hospitals, and mental health agencies or organizations.

Nursing Assistive Personnel (NAPs)** - Individuals trained to function in an assistive role to the licensed registered nurse in providing patient care activities as delegated by the Registered Nurses (RNs), regardless of the title of the individual to whom nursing functions are delegated. RNs may delegate selected nursing functions to NAPs who have appropriate education and competencies. The term NAP includes, but is not limited to, Certified Nursing Assistant, Nurse's Aide, Patient Care Technician, medication aides, orderlies, attendants, or technicians. NAPs are responsible for their actions in the performance of delegated nursing tasks and activities, while the supervising RN is accountable for the safety of the patient/client and the outcomes of nursing care.

Nursing delegation** - The act of transferring to a competent individual the responsibility to perform a selected nursing function in a selected situation within an authorized scope of practice, the process for doing the work while retaining professional accountability for the outcome of care. [See guidelines for nursing delegation in Recommendation #3]

Nursing process*** - A professional, systematic approach to ensuring complete care. The process consists of various steps including assessing, diagnosing, planning, implementing and evaluating the care provided.

Patient care systems - Include all the buildings, equipment, educated and trained healthcare professionals, ancillary personnel, and organizational structures that make it possible to provide patients with safe, quality care.

Patient-centered care - Care that puts the needs of the patient first.

Performance based incentives - Are usually monetary rewards for meeting performance standards set by the entities providing payment for services received. Health insurance companies, for example, may offer incentives for providing healthcare more efficiently, or for following “best-practices” in healthcare. The federal Centers for Medicare and Medicaid Services (CMS) and DHHS-Health Resources and Services Administration (HRSA) have several programs in which payment for healthcare services is tied to meeting performance standards for quality and safety in the provision of healthcare.

Practice efficiency - To practice the provision of healthcare in such a manner as to provide safe, high-quality patient-centered care, while expending only the necessary amounts of time, energy, equipment, supplies, and other resources.

Practice of nursing*** - The systematic application of substantial specialized scientific knowledge and skills to the diagnosis, care, treatment, prevention, counsel, health teaching, or relieving of human disease, ailment, defect, complaint, or other physical or mental condition. Nursing is a profession that is evidence-based, and requires an understanding of the human condition and applies the current science of professional caring to health goals mutually established with patients.

Practice of nursing as a Licensed Practical Nurse (LPN) - *Is the practice of a sub-field of nursing performed under the supervision of a registered nurse. [See Recommendation #4 for a more detailed definition]*

Professional Nurse - Includes the practice and profession of both an Advanced Practice Registered Nurse and Registered Nurse.

Regulation - 1) A law, rule or order prescribed by authority, especially to regulate conduct. 2) The act of regulating or the state of being regulated. [The Random House Dictionary of the English Language]

Registry - A hierarchical database that stores specified information. [Example: MCL: 483.156, Registry of Nurse Aides. This section spells out the specific requirements of the registry content for Nurse Aides.]

Scope of Practice for Registered Nurses** - *The complete Scope of Practice for Registered Nurses is stated in the most recent edition of the Nursing Scope and Standards of Practice of the American Nurses Association. The profession of nursing (Registered Nurses) has one scope of practice that encompasses the full range of nursing practice, pertinent to general and specialty practice. The individual registered nurses' ability to engage in the total scope of nursing practice is dependent on their required education, competency, experience, role, and the population served. The authority for nursing is based on a social contract and relationship with the public. Nursing is a dynamic discipline that increasingly involves more extensive knowledge, technologies and patient care activities.*

Simulation Technology - Provides healthcare students and practitioners with learning experiences that simulate real-life healthcare situations; treatments and procedures may be practiced, clinical decision-making and skills may be improved and situational protocols and interactions may be developed and tested. Simulations may range from single-skill mannequins (ex: a simulated human arm on which to practice IV insertions), to role-playing exercises that improve cultural competency, and communications with patients and care team members, to highly realistic mannequins programmed to present complex healthcare situations, to web-based environments (healthcare gaming) that simulate care settings, patients, and other providers. Simulations provide useful clinical experiences while maintaining patient safety.

Supervision*** - *The active process of directing, guiding and influencing the outcome of an individual's performance of a task. Supervision is generally categorized as on-site (the Registered Nurse (RN) being physically present or immediately available while the task is being performed) or off-site (the RN has the ability to provide direction through various means of written and verbal communication). Individuals engaging in supervision of patient care should not be construed to be managerial supervisors on behalf of the employer.*

Telehealth - *The use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, monitoring devices, and terrestrial and wireless communications. [U.S. Department of Health and Human Services- HRSA]*

Workarounds - A bypass of a recognized problem in a program or system without eliminating the problem. [Merriam-Webster]

* Adapted from National Council of State Boards of Nursing language

** Adapted from American Nurses Association and National Council of State Boards of Nursing language

*** Adapted from American Nurses Association language

Glossary of Nursing Practice Acronyms

APRN	Advanced Practice Registered Nurse
ADN	Associate's Degree in Nursing
BSN	Bachelor of Science in Nursing degree
COMON	Coalition of Michigan Organizations of Nursing
CNA	Certified Nursing Assistant
CRNA	Certified Registered Nurse Anesthetist
CNS	Clinical Nurse Specialist
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
HT	Healthcare Technology, including Healthcare Information Technology (HIT)
LPN	Licensed Practical Nurse
MACN	Michigan Association of Colleges of Nursing
MBON	Michigan Board of Nursing
MCNEA	Michigan Council of Nursing Education Administrators
MCN	Michigan Center for Nursing
MDCH	Michigan Department of Community Health
MONE	Michigan Organization of Nurse Executives
MSN	Master of Science in Nursing degree
NACN	National Association of Colleges of Nursing
NAP	Nurse Assistive Personnel
NCSBN	National Council of State Boards of Nursing
NLN	National League for Nursing
NP	Nurse Practitioner
OCNE	MDCH Office of the Chief Nurse Executive
RN	Registered Nurse
UAP	Unlicensed Assistive Personnel

Websites for Information on Nursing, Nursing Practice, and Health Policy

National Websites

Robert Wood Johnson Foundation: <http://www.rwjf.org/>, <http://www.rwjf.org/pr/topic.jsp?topicid=1318>, and www.rwjf.org/humancapital/pg.jsp.

National Council of State Boards of Nursing: www.ncsbn.org

Kaiser Family Foundation: <http://www.kff.org/>, <http://www.kaiserhealthnews.org/>, and www.kff.org/healthreform

American Nurses Association: www.ana.org

U.S. Department of Health and Human Services: Health Resources and Services Administration (HRSA): <http://www.hrsa.gov/index.html>

U.S. Department of Health and Human Services Center for Medicare and Medicaid: <http://www.cms.gov/>

AARP: Center for Championing Nursing in America: <http://www.championnursing.org/>

National Council on Aging: www.ncoa.org/straighttalk

Federal Trade Commission: <http://ftc.gov/>

Michigan Websites

State of Michigan Office of the Chief Nurse Executive: www.michigan.gov/mdch/ocne

State of Michigan Department of Licensing and Regulatory Affairs-Michigan Board of Nursing: http://www.michigan.gov/lara/0,1607,7-154-27417_27529_27542---,00.html

Michigan Public Health Institute-Center for Nursing Workforce and Policy: www.micnwp.org

Coalition of Michigan Organizations in Nursing: www.micomon.org

Michigan Center for Nursing: www.michigancenterfornursing.org

Michigan Executive Branch: <http://www.michigan.gov/snyder> and <http://www.michigan.gov/midashboard>

Michigan Health and Hospital Association: www.mha.org

Michigan Legislature: <http://www.house.michigan.gov/> and <http://senate.michigan.gov/>

Michigan Nurses Association: <http://www.minurses.org>

Registered Nurses Association in Michigan (RN-AIM): www.rn-aim.org (Michigan ANA affiliate)

Acknowledgements

The MDCH Task Force on Nursing Practice wishes to acknowledge and thank the following organizations, institutions, and individuals for their support in planning, conducting, and completing the work of the TFNP.

Thank you to all members of the Michigan nursing community and public who submitted nursing practice issue forms and all participants in the five regional TFNP forums – your contributions informed the deliberations of the TFNP and are an important part of the Task Force archives.

TFNP Forums were supported by staff support, services, and donations by:

Alliance for Health
Far Eastern American Nurses Association
Marquette General Hospital
Western Michigan Nursing Advisory Council

Thank you to all organizations, institutions, and individuals who contributed the time and energies of Task Force members, experts, and consultants to TFNP deliberations and the review of draft documents. We also thank staff in the offices of the TFNP members and TFNP Design Group members.

Michigan Department of Community Health – Director’s Office

Olga Dazzo
Melanie Brim

Michigan Department of Community Health

Monica Balderson
Linda Fox
Matthew Rick

Michigan Department of Licensing and Regulatory Affairs – Bureau of Health Professions

Rae Ramsdell

Michigan Public Health Institute – Center for Nursing Workforce and Policy

G. Elaine Beane
Emily Forrest
Kathleen C. Fordyce

TFNP Research Support

Bronson Medical Center: Vivien Mudgett
Northern Michigan Hospital: Jennifer Woods

The TFNP Final Report was produced by the Michigan Public Health Institute, with support from the Michigan Department of Community Health and funded by the Michigan Nurse Professional Fund.

This page intentionally left blank.